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MEDICAL EDUCATION PASSTHROUGH

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

S. 1158

JUNE 3, 1985

Printed for the use of the Committee on Finance

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MEDICAL EDUCATION PASSTHROUGH

MONDAY, JUNE 3, 1985

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senators Durenberger and Dole.

[The press release announcing the hearing, background material on S. 1158, and the prepared statements of Senators Dole, Bensten, and Mitchell follow:]

[Press Release No. 85-028]

HEARING ON MEDICAL EDUCATION PASS-THROUGH IS RESCHEDULED

A hearing on a legislative proposal to modify the Medicare direct medical education pass-through has been rescheduled for June 3, 1985, Senator Bob Packwood (R-Oregon), Chairman of the Committee on Finance, announced today.

The hearing before the Committee's Subcommittee on Health is scheduled to begin at 9:30 a.m., Monday, June 3, 1985, in Room SD-215, of the Dirksen Senate Office Building.

The hearing originally was scheduled for May 10 but was reset because of the delay in introduction of the legislative proposal by Senator Dave Durenberger (R-Minnesota), Chairman of the Subcommittee on Health. Senator Durenberger will preside at the June 3 hearing.

Senator Packwood said, "This delay will allow ample time for review and analysis of the bill in question by all interested parties. Additionally, the extra time permits the Committee to complete its solicitation of witnesses and compilation of testimony on this important health policy issue."

PAYMENTS FOR MEDICAL EDUCATION BY THE MEDICARE PROGRAM

Background Paper

Prepared for the Use of the Members of
the Committee on Finance

May 1985

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I. INTRODUCTION

Since its beginning in 1965, the Medicare program has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include salaries and fringe benefits for residents, faculty, and support staff; the cost of conference and classroom space in the hospital; any costs of additional equipment and supplies; and allocated overhead costs. The principal focus of this paper is on graduate medical education because physician training programs are the most costly component of the health professions education paid for under Medicare. In addition, very little data exist on the costs to Medicare of the nursing and other health training components.

Medicare's payments to hospitals for direct medical education costs are expected to be $1.3 billion in FY86. Medicare also pays teaching hospitals an additional amount to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in non-teaching hospitals. Medicare's payments for indirect teaching costs are expected to be $1.4 billion in FY86. Medicare is the single largest payer for health professions education in hospitals.

When the Medicare program was established, Congressional intent indicated that the program should support the clinical training of physicians, nurses, and other health personnel:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is

> intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. 1/

Recently, however, faced with a rising Federal deficit and future depletion of the Hospital Insurance Trust Fund which helps pay for hospital care for Medicare beneficiaries, this policy of support for health professions education has been questioned.

The current Medicare policy is open-ended because incurred costs of approved programs are reimbursed by Medicare regardless of the amount incurred and regardless of the number of programs or trainees, the length of training, or the type of training. Many observers see this policy as problematic for two main reasons. First, current projections indicate a substantial oversupply of personnel in certain health professions and in certain medical specialties but a shortage in other specialties by 1990. The Congress has already restricted support under other Federal health professions education programs (such as those authorized by the Public Health Service Act) to areas in which shortages exist, such as primary care physicians. Second, issues have been raised concerning Federal support for the clinical training of graduates of foreign medical schools, including the quality of their undergraduate training, the appropriateness of Federal funding for trainees who do not intend to practice in this country, and the contribution of those who stay to the oversupply of physicians in this country.

1/ U.S. Congress Senate. Social Security Amendments of 1965. Report of the Committee on Finance to accompany H.R. 6675 to Provide a Hospital Insurance Program for the Aged . . . . June 30, 1965. Washington, U.S. Govt. Print. Off., 1965. (89th Cong., 1st Sess. Senate Rept. No. 404, Part I), p. 36.

In response to these and other concerns, various proposals have been offered to change the way Medicare pays hospitals for health professions education. The Secretary of the Department of Health and Human Services (DHHS) published a proposed rule in the Federal Register (50 FR 21025) on May 21, 9185 that would limit Medicare's payments for direct medical education costs to Medicare's share of the lesser of the hospital's current direct costs for medical education activities or its costs in a base year. While this proposal would be initially applicable only for one year, the Secretary has indicated her intention to maintain fiscally equivalent limits on Medicare payments for the direct costs of graduate medical education in subsequent years. Another proposal provided for a capped level of support for direct medical education costs through block grants to the States, while encouraging States to increase their support (S. 3073, introduced by Sen. Durenberger in 1984).

Other proposals have focused on reducing the total number of students being trained by restricting support to certain types of trainees (e.g., those in short supply, those whose services are especially important in meeting the needs of the Medicare population, or those who are graduates of U.S. and Canadian medical schools or are U.S. citizens), or restricting support to a specific number of years. Still others have suggested requiring trainees to "pay back" Federal support by serving in health manpower shortage areas or providing services in Federal hospitals or primarily to Federal beneficiaries. Various proposals have also been made to change the way Medicare pays for the indirect costs of medical education.

Recently, several members of the Senate Finance Committee introduced S. 1158, which would reform the way the Medicare program pays for direct medical education costs. The bill provides for a 1-year freeze on such payments; a limit on the number of years of physician training Medicare will fund thereafter; exclusion of the costs of training alien foreign medical school graduates; and two studies to provide information for possible further reforms, including a study of nursing and other health professions training programs and a study of the differences in Medicare costs between patients treated in teaching hospitals versus non-teaching hospitals.

The Subcommittee on Health, Senate Committee on Finance, has scheduled a hearing on proposed legislation to modify Medicare's payments for the direct costs of health professions education. This document has been prepared to assist you in reviewing:

- --The nature of health professions education and the resulting supply of trained personnel;
- --The role of teaching hospitals in health professions education; and
- --Medicare's historical and current policies for making payments to hospitals for the cost of educational activities.

The document also includes:

- --A summary of S. 1158 and
- --An appendix which includes information on other sources of funding for health professions education.

II. HEALTH PROFESSIONS EDUCATION

Health education programs for the training of physicians, nurses, and other health professionals combine classroom training and learning through "hands on" experience. Classroom training is often conducted in a university setting and the "hands on" or clinical training is generally hospital-based.

This section focuses on the education of physicians since most of Medicare's expenditures for health professions education are associated with graduate medical education programs. However, this section also provides a brief discussion of the training of nurses and other health professionals. A discussion of graduates of foreign medical schools and the projected supply of physicians is also included.

A. Medical Education and Physician Supply

1. Organization of Medical Education Programs. Contemporary medical education (the training of physicians) generally includes four years of mediical school followed by residency training lasting three years or more. The four years of medical school are often referred to as undergraduate medical education, even though most medical students enter medical school after completing four years of study at an undergraduate institution. Residency training, which begins after the completion of medical school and the awarding of the medical degree, is referred to as graduate medical education.

a. Medical school training. Undergraduate medical school training typically consists of classroom instruction in the basic sciences and exposure to clinical medicine during periods known as clinical clerkships. During clerkships, medical school students are usually assigned to a hospital service where they assume responsibility for assessing and presenting to the faculty a specified number of cases each week. Students also participate with post-M.D. trainees (residents) and faculty in caring for patients admitted to the clinical service to which they are assigned.

b. Residency training. After completing undergraduate medical education and receiving the professional degree, most physicians enter a graduate medical education program, also known as a residency training program. Most States require that physicians have at least one year of graduate medical education before they become eligible for a license to practice medicine.

During residency training, knowledge and skills acquired in medical school are expanded through increasing personal responsibility for patient care in a structured and supervised clinical education environment. Residents in hospital-based graduate medical education programs, known as housestaff officers, provide care for patients, further their own education, and teach medical school students. As residents progress through their training programs, they gain increasing autonomy and responsibility for providing patient care services, and for teaching and supervising junior housestaff officers. There were 4,811 accredited graduate programs in medical education as of December 1984.

In order to be accredited, residency training programs must be in substantial compliance with published general requirements for graduate medical education and special requirements for training in a particular specialty. Standards and requirements for graduate medical education are developed and overseen by the Accreditation Council for Graduate Medical Education (ACGME), which is composed of representatives of the American Board of Medical Specialties, the

American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Speciality Societies. For approval of individual residency training programs, the ACGME has delegated authority to an appropriate residency review committee (RRC) which consists of representatives appointed by the American Medical Association, a particular specialty board, and in some cases, a national specialty society. The ACGME monitors RRC approvals with periodic reviews of their findings.

Generally, residency training programs are offered by hospitals which typically pay participating residents an annual stipend which varies with the year of residency training. In 1984-85, first-year residents receive stipends of about $20,000, while sixth-year residents receive stipends of approximately $27,000. In the course of completing a program, residents in some specialties such as preventive medicine, occupational health, and family practice may also be assigned to clinics or ambulatory centers not associated with a hospital.

Residency training is organized by specialty (e.g., internal medicine, surgery, etc.). Table 1 shows the distribution by specialty of the approximately 74,000 residents in 1984.

Table 1

NUMBER OF RESIDENTS RANK ORDERED BY SPECIALTY, 1984

SPECIALTY	# OF RESIDENTS	% OF TOTAL	CUMULATIVE
1. Internal Medicine	18,167	24.4	24.4
2. Surgery	8,189	11.0	35.4
3. Family Practice	7,408	9.9	45.3
4. Pediatrics	6,025	8.1	53.4
5. OB/GYN	4,615	6.2	59.6
6. Psychiatry	4,558	6.1	65.7
7. Anesthesiology	3,894	5.2	70.9
8. Radiology, Diagnostic	3,176	4.3	75.2
9. Orthopedic Surgery	2,842	3.8	79.0
10. Pathology	2,462	3.3	82.3
11. Opthalmology	1,569	2.1	84.4
12. Transitional Year*	1,480	2.0	86.4
13. Neurology	1,408	1.9	88.3
14. Emergency Medicine	1,108	1.5	89.8
15. Otolaryngology	1,047	1.4	91.2
16. Urology	1,043	1.4	92.6
17. Dermatology	779	1.0	93.6
18. Physical Medicine & Rehabilitation	712	1.0	94.6
19. Neurological Surgery	695	.9	95.5
20. Child Psychiatry	520	.7	96.2
21. Radiology, Therapeutic	519	.7	96.9
22. Plastic Surgery	430	.6	97.5

Footnotes shown on next page.

Table 1 (continued)

SPECIALTY	# OF RESIDENTS	% OF TOTAL	CUMULATIVE
23. Thoracic Surgery	292	.4	97.9
24. Allergy and Immunology	258	.3	98.2
25. Neonatal-Perinatal Medicine	216	.3	98.5
26. Nuclear Medicine	203	.3	98.8
27. Preventive Medicine General	199	.3	99.1
28. Pediatric Cardology	138	.2	99.3
29. Radiology, Diagnostic (Nuclear)	88	.1	99.4
30. Occupational Medicine	87	.1	99.5
31. Combined General Preventive Medicine/Public Health	58	.1	99.6
32. Aerospace Medicine	54	.1	99.7
33. Neuropathology	44	.1	99.8
34. Colon & Rectal Surgery	41	.1	99.9
35. Forensic Pathology	35	--	--
36. Blood Banking	34	--	--
37. Pediatric Surgery	27	--	--
38. Vascular Surgery	27	--	--
39. Public Health	25	--	--
40. Dermatopathology	23	--	--
Total	74,495		

---

* Transitional year programs provide a 12-month curriculum to residents who desire or are required to have experience in several medical clinical disciplines prior to undertaking further training in a single specialty.

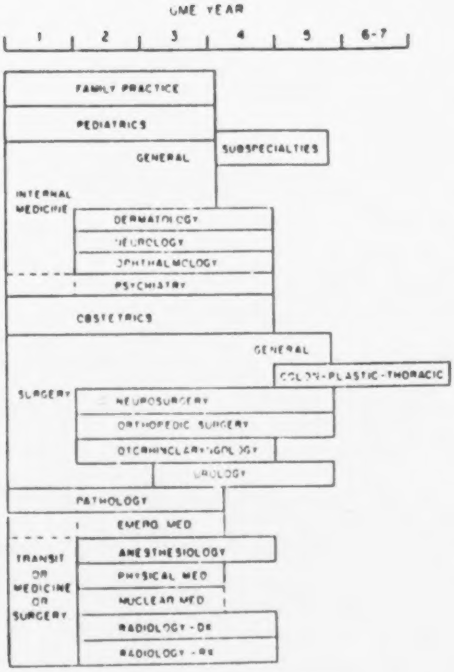
Source: 1985-1986 Directory of Residency Training Programs. American Medical Association. 1985.

c. Specialty requirements. Each of the medical specialties has established various requirements for residency training programs and for certification as a specialist upon completion of training. Training requirements include the content and length of the residency program. As shown in Chart 1, residency programs vary in length according to specialty, generally lasting from 3 to 7 years. For example, satisfactory completion of three years of training in family medicine, internal medicine, or pediatrics generally qualifies a doctor to sit for examination by the certifying boards of these specialties. Surgery requires five or more years of training depending on the subspecialty of surgery chosen.

Specialties such as family medicine, internal medicine, pediatrics, and surgery encourage students to enter their residency training programs directly after completing medical school and to continue in these programs until they have completed speciality board requirements. In other specialties, students are encouraged or required to spend their first graduate year in a residency program offering a broad clinical experience. Examples of these specialties are anesthesiology, dermatology, psychiatry, and radiology. Usually these students apply for a single year of internal medicine or for a diversified, traditional first graduate year with the expectation that they will enter a program in the specialty of their choice in their second graduate year. In some cases, a year of broad clinical experience may be provided in the same institution where subsequent specialty training occurs. In other instances, specialty training must be completed elsewhere.

Chart 1

Years Required for Training in Various Specialties



Source: NRMP Directory. National Resident Matching Program. Evanston, ILL. Oct. 1984., p. 18.

2. Foreign Medical Graduates. In 1984, 82 percent of the residents in graduate medical education programs were graduates of U.S. and Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME), the official accrediting body for educational programs leading to the medical degree in the U.S. and Canada. The remainder, 18 percent, were graduates of foreign medical schools.

Foreign medical graduates (FMGs) in residency training programs include:

(a) non-citizens who enter temporarily as exchange visitors for residency training and who are expected to return to their countries upon completion of training;

(b) non-citizens who are admitted permanently as immigrants to the U.S.; and

(c) U.S. citizens who graduate from foreign medical schools (USFMGs).

In 1984, there were 13,337 foreign medical graduates in residency training programs. Of this total, 7,314 were U.S. citizens and the remaining 6,023 were aliens. The American Medical Association estimates that 60 percent of alien FMGs in resident training in 1984 were admitted as permanent immigrants, 10 percent were exchange visitors, and the remaining 30 percent were of unknown status.

The percentage of total residents in graduate medical education who are FMGs has dropped from its peak of 33 percent in 1970 to 18 percent in 1984. The 1976 Amendments to the Immigration and Nationality Act (P.L. 94-484) have resulted in a decrease in the number of new exchange visitor physicians allowed to participate in residency training programs. In academic year 1973-74, more than 2,900 new exchange visitor physicians became eligible for residency training. In contrast, 598 new exchange visitor physicians became eligible in 1983-84. Across all years of residency training, only 1,678 exchange visitor FMGs were in graduate medical education positions in 1983-84, as compared to over 8,000 in 1973-74. In addition, the number of physicians admitted annually as permanent immigrants has declined. According to the U.S. Immigration and Naturalization Service, the number of physicians admitted as permanent immigrants declined from 4,537 in 1973-74 to 2,375 in 1983-84.

Despite this decline, the number of U.S.-citizen FMGs (USFMGs) increased substantially. USFMGs in graduate medical education rose from 4,229 in 1979 to 7,314 in 1984. These figures reflect an increase of 73 percent in the number of USFMGs participating in graduate medical education. Proportionally, USFMGs represented about 35 percent of all FMGs in 1979 compared to 55 percent in 1984.

For all graduates of foreign medical schools, certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is required for entry into accredited residency training programs in the U.S. The ECFMG is sponsored by the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, Association for Hospital Medical Education, Federation of State Medical Boards of the United States, and National Medical Association. In order to be certified by the ECFMG, FMGs must submit required medical credentials, demonstrate proficiency in English by passing the ECFMG English test, and pass a new two-day Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).[1] This exam consists of two parts: a basic science component administered on day one and a clinical science component administered on day two.

Table 2 shows the specialties in which alien FMGs, USFMGs, and graduates of U.S. and Canadian medical schools are training. In 1984, alien FMGs tended to specialize in fields such as pathology, pediatrics, and psychiatry. Fields such as internal medicine and surgery are preferred by all three groups. Family practice is of relatively the same interest for USFMGs as it is for medical graduates of U.S. and Canadian schools.

Table 2 also shows the relative proportion that alien FMGs, USFMGs, and graduates of U.S. and Canadian medical schools represent of total residents in training in the various specialties. Alien FMGs represent 27.3 percent of total residents in training in neuropathology, 20.4 percent of total residents in neonatalperinatal medicine, 17 percent of residents in pathology, 16.3 percent of residents in neurology, and 15.6 percent of residents in pediatrics and psychiatry. Together, alien and USFMGs constitute more than 25 percent of total residents in each of these specialties.

NUMBER AND PERCENT DISTRIBUTION OF RESIDENTS BY SPECIALTY
ACCORDING TO COUNTRY OF MEDICAL EDUCATION, 1984

	Number				Percent distribution						
Specialty	Total Residents	LCME graduates a/	USFMG	Alien FMG	Total	LCME graduates a/	USFMG	Alien FMG	USFMGs as percent of total	Alien FMGs as percent of total	USFMGs as percent of total FMGs
Allergy and Immunology	258	204	25	29	0.3	0.3	0.3	0.5	9.7	11.2	46.3
Anesthesiology	3,896	3,226	359	311	5.2	5.3	4.9	5.2	9.2	8.0	53.6
Colon and Rectal Surgery	41	29	5	7	*	*	*	0.1	12.2	17.1	41.7
Dermatology	779	732	22	25	1.0	1.2	0.3	0.4	2.8	3.2	46.8
Dermatopathology	23	17	2	4	*	*	*	*	8.7	17.4	33.3
Emergency Medicine	1,108	1,042	54	12	1.5	1.7	0.7	0.2	4.9	1.1	81.8
Family Practice	7,408	6,432	804	172	9.9	10.5	11.0	2.9	10.9	2.3	82.4
Internal Medicine	18,167	14,116	2,315	1,736	24.4	23.1	31.7	28.8	12.7	9.6	57.1
Neurological Surgery	695	634	33	28	0.9	1.0	0.5	0.5	4.7	4.0	54.1
Neurology	1,408	1,022	156	230	1.9	1.7	2.1	3.8	11.1	16.3	40.4
Nuclear Medicine	203	131	29	43	0.3	0.2	0.4	0.7	14.3	21.2	40.3
Obstetrics/Gynecology	4,615	4,042	373	200	6.2	6.6	5.1	3.3	8.1	4.3	65.1
Ophthalmology	1,569	1,510	37	22	2.1	2.5	0.5	0.4	2.4	1.4	62.7
Orthopedic Surgery	2,842	2,778	48	16	3.8	4.5	0.7	0.3	1.7	0.6	75.0
Otolaryngology	1,047	996	32	19	1.4	1.6	0.4	0.3	3.1	1.8	62.7
Pathology	2,462	1,803	241	418	3.3	2.9	3.3	6.9	9.8	17.0	36.6
Blood Banking	34	29	2	3	*	*	*	*	5.9	8.8	40.0
Forensic Pathology	35	28	7	0	*	*	*	*	20.0	0.0	100.0
Neuropathology	44	29	3	12	*	*	*	0.2	6.8	27.3	20.0
Pediatrics	6,025	4,338	750	937	8.1	7.1	10.3	15.6	12.4	15.6	44.5
Pediatric Cardiology	138	113	12	13	0.2	0.2	0.2	0.2	8.7	9.4	48.0
Neonatal-Perinatal Medicine	216	143	29	44	0.3	0.2	0.4	0.7	13.4	20.4	39.7
Physical Medicine and Rehabilitation	712	470	139	103	1.0	0.8	1.9	1.7	19.5	14.5	57.4
Plastic Surgery	430	379	32	19	0.6	0.6	0.4	0.3	7.4	4.4	62.7
Preventive Medicine, General	199	170	9	20	0.3	0.3	0.1	0.3	4.5	10.1	31.0
Aerospace Medicine	54	51	1	2	*	*	*	*	1.9	3.7	33.3
Occupational Medicine	87	71	6	10	0.1	0.1	*	0.2	6.9	11.5	37.5
Public Health	25	19	2	4	*	*	*	*	8.0	16.0	33.3
Combined General Preventive Medicine/Public Health	58	54	3	1	*	*	*	*	5.2	1.7	75.0
Psychiatry	4,558	3,250	610	698	6.1	5.3	8.3	11.6	13.4	15.3	46.6
Child Psychiatry	520	367	72	81	0.7	0.6	1.0	1.3	13.8	15.6	47.1
Radiology, Diagnostic	3,176	2,904	171	101	4.3	4.7	2.3	1.7	5.4	3.2	62.9
Radiology, Diagnostic (Nuclear)	88	76	7	5	0.1	0.1	0.1	*	8.0	5.7	58.3
Radiology, Therapeutic	519	402	41	76	0.7	0.7	0.6	1.3	7.9	14.6	35.0
Surgery	8,189	7,116	632	443	11.0	11.6	8.6	7.4	7.7	5.4	58.8
Pediatric Surgery	27	25	2	0	*	*	*	*	7.4	0.0	100.0
Vascular Surgery	27	27	0	0	*	*	*	*	0.0	0.0	0.0
Thoracic Surgery	292	263	12	17	0.4	0.4	0.2	0.3	4.1	5.8	41.4
Urology	1,063	887	113	63	1.4	1.4	1.5	1.0	10.6	5.9	64.2
Transitional Year	1,480	1,257	124	99	2.0	2.1	1.7	1.6	8.4	6.7	55.6
Total	74,495	61,158	7,314	6,023	100.0	100.0	100.0	100.0	9.8	8.1	54.8

*/ Less than 0.1 percent

a/ Includes graduates of U.S. and Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME), the official accrediting body for education programs leading to the medical degree

Source: 1985-1986 Directory of Residency Training Programs. American Medical Association, 1985.

Table 3 presents data on the distribution of FMG residents by State. For 1984, the greatest concentration of FMG residents exists in New Jersey where 61.3 percent of all residents are FMGs, New York where 37.8 percent of residents are FMGs, Illinois with 27.0 percent, Connecticut with 23.5 percent, Delaware with 23.3 percent, and Michigan with 21.9 percent.

The AMA indicates that in 1984, in 1,209 residency training programs (one-fourth of all programs), more than 25 percent of the residents in each program were FMGs. FMGs in these programs represented 78 percent of total FMGs in residency training. Among the locations of these programs were approximately 25 inner-city hospitals in cities such as New York, Los Angeles, Detroit, and Chicago. According to the AMA, more detailed information is not currently available about hospitals where FMGs might be concentrated.

Table 3

—Number and Percent of FMG Residents on Duty September 1, by Geographic Location of Program

	1982		1983		1984	
Region/State	Total FMGs	% of FMGs	Total FMGs	% of FMGs	Total FMGs	% of FMGs
NEW ENGLAND	871	16.8	742	14.1	751	13.8
Connecticut	388	26.8	332	22.9	357	23.5
Maine	5	3.5	8	5.3	9	5.8
Massachusetts	388	12.3	325	11.0	314	10.4
New Hampshire	7	4.4	6	3.8	3	1.9
Rhode Island	54	15.2	65	17.3	62	15.8
Vermont	7	4.1	6	3.5	6	3.4
MIDDLE ATLANTIC	6,098	37.1	6,094	38.7	6,185	38.0
New Jersey	1,139	61.4	1,224	64.0	1,240	61.3
New York	4,147	40.4	4,028	38.2	4,129	37.8
Pennsylvania	812	18.8	842	18.2	816	17.2
EAST NORTH CENTRAL	2,649	20.8	2,543	20.0	2,604	18.7
Illinois	1,043	26.6	1,035	25.7	1,136	27.0
Indiana	35	4.1	38	4.2	42	4.5
Michigan	820	22.2	711	25.9	669	21.9
Ohio	663	18.8	651	18.2	648	17.0
Wisconsin	88	7.6	108	8.9	109	8.9
WEST NORTH CENTRAL	457	9.4	528	10.4	523	10.4
Iowa	40	6.0	41	6.0	42	6.0
Kansas	70	11.6	69	11.5	60	10.2
Minnesota	72	4.6	77	4.7	90	5.9
Missouri	219	14.2	271	18.0	249	14.7
Nebraska	40	12.0	51	15.8	58	16.3
North Dakota	10	11.9	13	15.7	17	17.7
South Dakota	6	8.3	6	7.2	7	7.8
SOUTH ATLANTIC	1,385	13.8	1,353	12.9	1,313	12.0
Delaware	42	28.8	36	23.4	35	23.3
District of Columbia	280	17.9	255	16.0	250	15.6
Florida	397	22.6	386	21.7	341	19.4
Georgia	71	6.0	75	6.3	86	6.7
Maryland	369	24.2	394	22.4	378	19.7
North Carolina	69	4.8	73	4.8	69	4.2
South Carolina	13	1.9	22	3.2	34	4.6
Virginia	94	7.1	68	4.8	69	4.8
West Virginia	50	12.7	44	10.7	51	11.9
EAST SOUTH CENTRAL	280	9.1	300	9.8	294	8.9
Alabama	40	5.2	50	6.3	59	7.0
Kentucky	90	12.7	80	11.9	69	9.6
Mississippi	16	4.9	19	5.5	17	4.7
Tennessee	134	10.7	151	12.4	149	11.0
WEST SOUTH CENTRAL	556	9.3	590	9.2	578	8.8
Arkansas	5	1.5	8	2.1	17	4.1
Louisiana	174	14.4	200	14.9	181	13.2
Oklahoma	44	8.5	66	10.5	58	8.7
Texas	333	8.5	316	7.8	322	7.5
MOUNTAIN	76	3.5	100	4.3	105	4.8
Arizona	39	5.7	51	6.7	48	6.6
Colorado	24	2.8	27	2.9	26	2.9
Montana	0		0		0	
New Mexico	3	1.3	6	2.6	18	7.4
Utah	10	2.7	15	4.3	12	2.9
Wyoming	0		1	2.5	1	2.4
PACIFIC	753	8.8	702	8.0	692	7.7
Alaska	0		0		0	
California	691	10.0	628	9.1	632	8.8
Hawaii	14	5.0	17	4.7	15	4.1
Idaho	0		0		0	
Nevada	10	18.2	10	12.7	9	11.2
Oregon	15	3.2	25	5.0	20	4.2
Washington	23	2.7	22	2.5	16	1.7
TERRITORY	268	40.2	269	35.0	304	36.6
Puerto Rico	268	40.2	269	35.0	304	36.6
Total	13,123	19.0	13,221	18.4	13,337	17.9

Source: 1985-1986 Directory of Residency Training Programs. American Medical Association, 1985. Table 14, p. 93.

Available data on the length of time alien FMG residents remain in the U.S. is very limited. As noted above, the AMA estimated that 60 percent of alien FMG residents in training programs in 1984 who were listed in the physician masterfile were admitted as permanent immigrants, indicating that these persons probably intend to remain indefinitely and perhaps become U.S. citizens. Exchange visitor residents (estimated to be 10 percent of alien FMG residents in training in 1984), on the other hand, are generally required to return to their homeland upon completion of their training.

These estimates provide the best available information concerning the current distribution of alien FMGs in training between the two categories of immigration status. It should be noted, however, that the AMA was unable to determine the status of 30 percent of alien FMG residents in training in 1984. Thus, even though 60 percent of alien FMGs could be expected to remain in the U.S., the percentage of alien FMGs who actually do so is uncertain.

Some historical data on this question is provided by a study in which the AMA and the ECFMG examined a population of FMGs who came to the U.S. and took their initial ECFMG certifying examination between the years 1969 and 1982 to determine how many of these individuals remained in the U.S. Of this population, 55,080 were identified on the AMA physician masterfile as having received residency training or practiced in the U.S. As indicated in Table 4, a preliminary analysis of this population shows that 92.9 percent of alien FMGs were still in the country as of mid-year 1984, and 99.6 percent of USFMGs remained. It should be noted, however, that many of the alien FMG residents identified in this study entered the U.S. before enactment of the 1976 Amendments to the Immigration and Nationality Act (P.L. 94-484) which strengthened the requirements that alien FMGs must meet to qualify for entry and which have made it more difficult for exchange visitors to remain once their training is completed.

TABLE 4. Foreign Medical Graduates in the AMA/ECFMG Study Population* Who Remained in the U.S. as of Mid-Year 1984--Preliminary Findings

	Total study population	Remaining in the U.S. as of mid-year 1984	
		Number	Percent
United States Foreign Medical Graduates	10,515	10,478	99.6%
Alien Foreign Medical Graduates	44,565	41,425	92.9%
Total	55,080	51,903	94.2%

*The AMA/ECFMG Study Population is a subset of the candidates for ECFMG certification who took their first ECFMG exam between the years 1969 and 1982. The AMA identified 55,080 of these candidates who came to the U.S.

Source: Loft, JD, et al: Professional Practice Characteristics of Foreign Medical Graduates, American Medical Association. Forthcoming.

Table 5 presents preliminary findings of an AMA analysis of foreign medical graduates--both physicians in practice and residents in training--by country of graduation as of December 31, 1983. Of the 112,005 FMGs in the country at the end of 1983, 71.5 percent were alien FMGs and 28.5 percent were USFMGs. Among alien FMGs, almost 61 percent had graduated from Asian schools, with Indian and Philippine graduates representing the largest portion. Graduates of European schools were the next largest group, representing 17 percent of total alien FMGs.

Among USFMGs, graduates of European schools represented 57 percent of the total, and graduates of Central American and Caribbean schools, the next largest group, with 27 percent of the total.

Table 5

FEDERAL AND NON-FEDERAL FOREIGN MEDICAL GRADUATES BY COUNTRY OF GRADUATION AND AGE, DECEMBER 31, 1983

Preliminary Findings

COUNTRY OF GRADUATION	TOTAL FMGS	Total Alien FMGS	TOTAL USFMGS
TOTAL FMGS	112,005	80,044	31,961
AFRICA	3,640	3,336	304
EGYPT	1,993	1,794	199
GHANA	90	90	...
NIGERIA	153	147	6
SOUTH AFRICA	1,180	1,090	90
UGANDA	85	84	1
OTHER AFRICA	139	131	8
ASIA	52,449	48,656	3,793
INDIA	17,991	17,578	413
IRAN	2,845	2,628	217
ISRAEL	806	667	139
JAPAN	819	711	108
KOREA (SOUTH)	4,446	4,060	386
LEBANON	1,168	910	258
PAKISTAN	2,214	2,159	55
PHILIPPINES	13,752	12,307	1,445
TAIWAN	2,557	2,413	144
THAILAND	1,382	1,345	37
OTHER ASIA	4,471	3,878	593
CENTRAL AMERICA	16,370	7,653	8,717
CUBA	3,500	2,419	1,081
DOMINICAN REPUBLIC	2,273	940	1,333
HAITI	711	652	59
JAMAICA	355	331	24
MEXICO	7,720	2,409	5,311
OTHER CENTRAL AMERICA	1,811	902	909
EUROPE	31,756	13,552	18,204
AUSTRIA	1,340	242	1,098
BELGIUM	1,211	371	840
GERMANY (WEST)	3,178	1,132	2,046
GREECE	1,225	722	503
IRELAND	1,345	850	495
ITALY	4,465	893	3,572
SPAIN	3,712	1,384	2,328
SWITZERLAND	2,412	452	1,960
U S S R.	1,336	775	561
UNITED KINGDOM	3,589	2,360	1,229
OTHER EUROPE	7,943	4,371	3,572
SOUTH AMERICA	6,922	6,058	864
ARGENTINA	2,062	1,741	321
BRAZIL	694	626	68
CHILE	509	457	52
COLOMBIA	1,454	1,259	195
PERU	1,050	934	116
OTHER SOUTH AMERICA	1,153	1,041	112
OCEANIA	868	789	79
AUSTRALIA	688	622	66
NEW ZEALAND	177	165	12
OTHER OCEANIA	3	2	1

Source: Eiler, MA and Loft, JD: A Profile of Foreign Medical Graduates, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, Forthcoming.

3. Past and Future Physician Supply and Distribution. During the recent past, there has been a rapid and large increase in the number of physicians in the country. In 1950, there were approximately 220,000 M.D.s in the U.S., representing a ratio of 134 physicians per 100,000 population. In the mid-1960s, concern was expressed about shortages of physicians and other health professionals in the nation. Efforts were made to create more medical schools, increase class sizes in medical schools, and ease restrictions on the influx of graduates of foreign medical schools into the country. Consequently, by 1975, the number of M.D.s in the country had increased to 393,742 for a physician ratio of 179 per 100,000 population. This number further increased, as reflected in American Medical Association (AMA) data, to 501,958 physicians in 1982, resulting in a physician-to-population ratio of 213 per 100,000.

In the 1960s and through 1970, a number of reports attested to the seriousness and scope of health personnel shortages. As late as 1970, the Carnegie Commission on Higher Education stated in a report: "The most serious shortages of professional personnel in any major occupation group in the United States are in health services." Among other things, the Commission recommended a 50 percent increase in first-year enrollments at medical schools to help eliminate a shortage of some 50,000 physicians.

In order to alleviate shortages, Congress in 1963 established in Title VII of the Public Health Service Act programs of direct Federal support for health professions education. Direct Federal support became available for programs designed to increase enrollments and graduates of health professions schools. There were also various student assistance programs enacted, including scholarship programs and loan programs and the National Health Service Corps scholarship program. Under this latter program, students who receive scholarship assistance are then obligated to practice in a health manpower shortage area.

When in 1974 the Congress began to consider revision and extension of health manpower training programs, the need to increase the aggregate supply of health personnel no longer commanded the attention and concern it had in prior years. This was, in part, the result of an awareness that Federal support had provided substantial increases in enrollments at health professions schools. For example, first-year enrollments at medical schools increased from 8,772 in 1963-64 to 14,159 in 1973-74. Today, that number is over 16,000.

In addition, in 1974 there were the very first suggestions that the aggregate supply of health professionals would be sufficient in the near future. During hearings before the Congress in 1974, the Assistant Secretary for Health of the Department of Health, Education and Welfare estimated that by 1980, the nation's supply of physicians would likely be adequate to meet projected requirements for physician manpower.

Instead, observers pointed to problems associated with the speciality and geographic maldistribution of health professionals. The nation still lacked health personnel in many rural and inner-city areas. In addition, there were thought to be too many surgeons, neurologists, radiologists, and other specialists, and not enough primary care physicians. Congress also perceived that health professionals could assume more of the cost of their education, since their education provided them with potentially high-paying careers.

Thus by 1976, Congress had begun to refocus Federal assistance on special projects which would encourage health personnel to practice in medically underserved areas, which would increase the number of primary care practitioners, and which would support other national health professions training objectives. In addition, in 1976, Congress began to limit financial assistance for students.

In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) issued its findings on the supply of and requirements for physicians in the 1990's. GMENAC had been established in 1976 by the Secretary of the Department of Health and Human Services (then the Department of Health, Education, and Welfare) to study, among other things, the future supply of physicians in the country and the number required to meet the health care needs of the nation as well as the most appropriate specialty distribution of these physicians.

GMENAC estimated future physician requirements on the basis of an "adjusted need" for medical services, that is, the quantity of services which expert medical opinion believes ought to and can be consumed over a specified period of time for persons to stay or become as healthy as possible given existing medical knowledge. Through a combination of empirical data and professional judgment, GMENAC arrived at estimates of appropriate utilization of medical services. In summary, this approach generated physician service requirements as a function of expected national morbidity, first modified by expert opinion of what fraction of this morbidity should require medical intervention, and then modified by estimates of the constraints of the existing health care system.

In 1980 when its report was issued, GMENAC estimated that by 1990, there would be a surplus of 70,000 physicians in the country (536,000 supply, 466,000 required) and by the year 2000, this surplus would increase to 145,000 (643,000 supply, 498,000 required). In the GMENAC report, requirements for six of the 32 specialties and subspecialties studied by GMENAC were based on a review of relevant literature and could not be modeled as intensively as the other specialties because of timing and resource constraints. Since then, the full needs-based approach has been applied to these six specialties. The refined estimation of these six specialties resulted in a decrease in the aggregate physician surplus projected by GMENAC from 70,000 to 63,000 more physicians than required in 1990 (536,000 supply, 473,000 required).

A different approach to projecting supply and requirements for physicians has been undertaken by the Bureau of Health Professions (BHPr), Department of Health and Human Services. The BHPr modeling approach assumes that recent patterns of medical services utilization and productivity will continue into the future. It is described as an "adjusted utilization" approach because estimates of requirements for physician services are made by adjusting current levels of utilization by projected changes in the population, trends in per capita utilization, and other factors affecting utilization, such as the prices of services and health insurance coverage. The BHPr model estimates that for 1990 there will be a excess of 35,300 physicians in the country (594,600 supply, 559,300 required) and an excess of 51,800 physicians in the year 2000 (706,500 supply, 654,700 required).

It should be noted that even with an overall surplus, the distribution of physician supply relative to projected need varies greatly by specialty. GMENAC provided estimates of the magnitude of surpluses or shortages in each of the medical specialties. As can be seen in Table 6, the specialties projected to have the greatest surpluses are pulmonary-internal medicine, neurosurgery, endocrinology-internal medicine, and cardiology-internal medicine. Specialties with the greatest projected shortages include child psychiatry, physical medicine and rehabilitation, emergency medicine, preventive medicine, and general psychiatry.

Table 6

Table B-1-28. RATIO % OF PROJECTED SUPPLY TO ESTIMATED REQUIREMENTS--1990

	Ratio %	Requirements	Surplus (Shortage)
Shortages			
Child Psychiatry	45%	9,000	(4,900)
Physical Medicine and Rehabilitation	60%	4,050	(1,650)
Emergency Medicine	70%	13,500	(4,250)
Preventive Medicine	75%	7,300	(1,750)
General Psychiatry	80%	38,500	(8,000)
Near Balance			
Therapeutic Radiology	85%	2,550	(400)
Anesthesiology	90%	22,150	(2,000)
Hematology/Oncology-Internal Medicine	90%	9,000	(700)
Dermatology	105%	6,950	400
Gastroenterology-Internal Medicine	105%	6,500	400
Osteopathic General Practice	105%	22,750	1,150
Family Practice	105%	61,300	3,100
General Internal Medicine	105%	70,250	3,550
Otolaryngology	105%	8,000	500
Pathology	105%	15,900	950
Neurology	105%	8,350	300
General Pediatrics & Subspecialties	115%	36,400	4,950
Surpluses			
Urology	120%	7,700	1,650
Diagnostic Radiology	135%	19,200	6,450
Orthopedic Surgery	135%	15,100	5,000
Ophthalmology	140%	11,600	4,700
Thoracic Surgery	140%	2,050	850
Infectious Diseases-Internal Medicine	145%	2,250	1,000
Obstetrics/Gyncology	145%	24,000	10,450
Plastic Surgery	145%	2,700	1,200
Allergy/Immunology-Internal Medicine	150%	2,050	1,000
General Surgery	150%	23,500	11,800
Nephrology-Internal Medicine	175%	2,750	2,100
Rheumatology-Internal Medicine	175%	1,700	1,300
Cardiology-Internal Medicine	190%	7,750	7,150
Endocrinology-Internal Medicine	190%	2,050	1,800
Neurosurgery	190%	2,650	2,450
Pulmonary-Internal Medicine	195%	3,600	3,350
Nuclear Medicine	N/A	4,300	N/A

Supply numbers for nuclear medicine are not available.

Note: This table has been revised from the original GMENAC Summary Final Report (1980) to incorporate the results of the revised requirements for the six specialties of anesthesiology, neclear medicine, pathology, physical medicine and rehabilitation, and diagnostic and therapeutic radiology.

Estimates have been rounded to nearest 50.

Sources: Report to the President and Congress on the Status of Health Personnel in the United States, v. 2. U.S. Department of Health & Human Services. May 1984. Table B-1-28, p. B-1-31.

In its Report to the President and the Congress on the Status of Health Personnel in the United States (May 1984), the Department of Health and Human Services noted that: "The specialty distribution of health professionals continues to be an area of concern. In particular, there is concern about adequate access to the services of primary care physicians. Although the number of primary care physicians (general/family practitioners, internists, and pediatricians) continued to increase in recent years, their percentage of all physicians has remained relatively constant at about 40 percent."

B. Nurse and Other Health Professional Education

Nursing education has evolved from what was once primarily three years of hospital-based training to several curricula which are becoming more closely affiliated with or sponsored by colleges or universities. While the classroom training is now more likely to be in a college or university, hospitals remain the primary sites for undergraduate clinical training of nurses.

Three types of programs awarding different credentials prepare their graduates for licensure as registered nurses: diploma, associate degree, and baccalaureate degree programs. Generally, diploma programs are 3 years in length, and usually based in a hospital. Students in diploma programs usually receive classroom instruction and three to four semesters of clinical training, which takes place most often in the general care units of a hospital. Associate degree programs are primarily 2 years in length and located mainly in junior or community colleges. Like diploma degree students, those enrolled in associate degree programs receive classroom instruction and spend three semesters in clinical training, usually in general care units of a hospital. Baccalaureate programs generally require four years of study, including four to five semesters of clinical training. Most of this training takes place in the critical care units as well as general care units of the hospital. In addition, a significant portion of the clinical training of baccalaureate students takes place in comcommunity health agencies, home health agencies, nursing homes, and other outpatient settings.

While the total number of State Board-approved nursing education programs has grown somewhat over the past two decades, the mix of the three types of programs has changed dramatically. Of the 1,432 approved programs (with 242,035 students) in 1982, only 20 percent (288 programs with 42,348 students) were diploma programs compared with 80 percent (900 programs with 94,161 students) in 1960; associate degree programs accounted for 52 percent in 1982 (742 programs with 105,324 students), up from 5 percent (57 programs with 3,254 students) in 1960; and baccalaureate programs accounted for 28 percent in 1982 (402 programs with 94,363 students), compared with 15 percent (171 programs with 20,748 students) in 1960.

Basic nursing education provides a foundation for practice as a registered nurse; however, many advanced nursing positions (for example, clinical specialist, supervisor/administrator, or educator) require education and clinical training beyond the basic level. About 13 percent, or 213,000 registered nurses, are estimated to have graduated from academic programs which are beyond the basic level. These programs generally consist of clinical training as well as classroom instruction. However, the length and site of the clinical training required for advanced nursing positions varies by program and specialty. For example, much of the clinical training of a clinical nurse specialist will take place in the intensive care unit of a hospital. A family nurse practitioner, on the other hand, will receive most of his or her clinical training in a community agency or doctor's office. Training beyond the basic level may or may not lead to a master's or other academic degree.

In addition to programs which prepare registered nurses, other programs prepare students to provide nursing services under the supervision of a registered nurse or physician as a licensed practical or vocational nurse. As of October 1982, there were 1,295 State Board-approved programs (with 57,367 students) preparing students to become licensed practical or vocational nurses. The majority of these programs are located in trade, technical, or vocational schools. About three out of ten are in junior or community colleges, while some are in hospitals and some in secondary schools. The number of programs located in hospitals has been declining; some 15 percent of programs in 1971 were in hospitals and only 8 percent in 1981, the last year for which such data were available.

Other health professions training programs train pharmacists, administrators, technologists, therapists, and others who perform relatively high-level health care functions, technicians and assistants whose duties vary greatly in complexity, and aides who perform routine supportive services. Other health occupations include dietitians, physical therapists, speech pathologists, laboratory technicians, and nuclear medicine technologists. These, however, are only a few of at least 140 health occupations. The range of services rendered by other health professionals includes emergency services, initial evaluation, treatment, therapy, testing, fitting of medical devices, record maintenance, acute care, long-term care, and rehabilitation.

Because of this variety in function, the scope of other health professions education is similarly broad, ranging from limited post-secondary training to post-doctoral training. According to the 1984 Report to the President and Congress on the Status of Health Personnel in the United States by the Bureau of Health Professions, Department of Health and Human Services (DHHS), it is not possible with certainty to inventory all health training programs, academic and nonacademic, accredited and nonaccredited. However, this report estimates that in 1979-80, there were approximately 475,000 students enrolled in non-physician health education programs in all settings, including collegiate and noncollegiate settings. A 1979-80 survey of collegiate health programs indicated that approximately 325,000 students were enrolled in non-physician health educational programs in collegiate settings. Only rough approximations of enrollments in programs in other institutions can be made: 65,000 in hospital-based programs, 40,000 in military programs, and 45,000 in other nonmilitary settings, such as vocational-technical or proprietary schools.

The length of a program a student must complete to qualify for entry into non-physician health occupations varies by occupation. However, training for most health occupations follows the general model of classroom and clinical training. For collegiate programs, the most commonly used clinical facility is the hospital. However, many programs are affiliated with other settings; for example, programs for occupations with both a patient care and health promotion focus (dental hygienist and various types of therapists) tend to expose their students to a variety of settings outside the hospital.

III. HEALTH PROFESSIONS EDUCATION IN HOSPITALS

A. Characteristics of Teaching Hospitals

Clinical training for both undergraduate and graduate health professions education in this country is generally conducted in the hospital setting. Approximately 18 percent of all U.S. hospitals offer teaching programs, which vary considerably in terms of their size and diversity. Teaching hospitals may have programs for the training of physicians (i.e., graduate medical education), nurses, or other health personnel such as dietitians, emergency medical technicians, occupational therapists, and physical therapists.

The number of teaching hospitals in the country depends on the definition of teaching hospital used. Approximately 1,200 hospitals (18 percent of all U.S. hospitals) participate in at least one residency program. Approximately 1,100 of these are affiliated with medical schools. However, only about 400 hospitals meet the requirements for membership in the Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges. These requirements include sponsorship of at least four approved residency programs 2/ and recommendation for membership by an accredited medical school with which the hospital is affiliated. Although data gathered by COTH from its members represent teaching hospitals with major graduate medical education programs

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2/ That is, those accredited by the Accreditation Council for Graduate Medical Education or by the Residency Review Committee for the specific clinical specialty.

and understate the number and variety of teaching hospitals in the country, little data about other teaching hospitals exist.

Major teaching hospitals are generally committed to at least three distinct objectives: 1) providing patient care, 2) training health professionals, and 3) conducting clinical research. The interrelationships of these three activities within the teaching hospital create an institution which is in many ways different from the single purpose non-teaching hospital. These interrelationships also make it difficult to separate the health professions education activities of a teaching hospital from its other activities, particularly patient care. Each of these objectives of the teaching hospital is discussed in more detail below, using 1980 data from the COTH on its member hospitals.

1. Patient Care. Major teaching hospitals tend to be very large hospitals (75 percent of COTH hospitals had over 400 beds, compared to only 7 percent of non-COTH hospitals). COTH hospitals (75 percent as compared to 55 percent for non-COTH hospitals) tend to be organized as nonprofit entities. COTH hospitals are concentrated primarily in urban areas (97 percent of COTH hospitals compared to 47 percent of non-COTH hospitals) in the Northeast region of the country. COTH hospitals on average employed almost six times the number of full-time equivalent personnel employed in non-COTH hospitals.

Although COTH hospitals represented only 6 percent of all short-term non-Federal hospitals in 1980, they accounted for 18 percent of admissions, 19 percent of beds, 21 percent of the births, and 30 percent of the outpatient visits. Teaching hospitals provide a wide range of hospital services, many of which (such as burn care units, organ banks, and open heart surgery) are typically unavailable in nonteaching community hospitals. As a result, patients with the most severe medical problems tend to be referred to major teaching hospitals for the latest techniques and equipment used in patient care.

Teaching hospitals also have historically played a major role in providing care for economically disadvantaged patients. Although admitting 18 percent of the country's patients, COTH hospitals accounted for 25 percent of all Medicaid admissions. In addition, these hospitals had a higher-than-average share of patient bad debt and charity care (9 percent of patient revenues in COTH hospitals in 1980 compared to 5 percent in non-COTH hospitals).

2. Clinical Education. The teaching hospital is the setting for most of the clinical training for health professions in this country. According to American Hospital Association data for 1983, U.S. hospitals provided training sites for approximately 71,000 medical and dental residents and for 9,000 other trainees, including nurses, technicians, and medical students in their last two years of medical school. In 1983, 1,200 hospitals had residency programs and 280 had professional nursing schools. In 1980, the 400 COTH hospitals trained 71 percent of all residents and 36 percent of all nursing and other health trainees.

Historically, hospitals that provided the opportunity for medical school graduates to gain practical experience were not affiliated with, or owned by, medical schools. Today, however, although free-standing residency programs may still be established, staffed, and controlled by an individual hospital, more commonly there exists some affiliation between the medical school and the teaching hospital. The term "academic health center" has been used to describe a constellation of institutions which provide undergraduate and graduate training in a variety of health professions. An academic health center can include medical schools, teaching hospitals, and often other professional and allied health schools, biomedical research institutions, ambulatory care centers, rehabilitation institutes, and health maintenance organizations.

3. Clinical Research and Applied Technology. Many advances in the medical sciences began in the basic research laboratories of universities and their affiliated hospitals and were then applied to patient care in clinical research programs at teaching hospitals. While most of the nation's clinical research takes place in teaching hospitals, not all teaching hospitals are equally involved in medical research. Generally, involvement in medical research projects is extensive where the hospital's medical staff is composed primarily of full-time faculty physicians. Medical research is typically less extensive where the hospital's medical staff is composed of physicians in private practice. A major commitment on the part of a teaching hospital to medical research results in certain managerial and financial implications for the hospital. For example, research programs often alter the mix of services and the cost of care for patients in experimental care programs.

B. Measuring the Cost of Health Professions Education in Hospitals

The costs of delivering patient care in teaching hospitals are consistently higher than in non-teaching hospitals. Simple cost comparisons, for example, show that in 1981 the average cost of care in COTH hospitals was $3,281 per adjusted admission, nearly twice as high as the average of $1,683 in non-COTH hospitals. These cost differences reflect many of the differences in objectives and other characteristics (such as location and size) between teaching and non-teaching hospitals which were described earlier in this paper.

Teaching hospitals incur additional costs because of their educational activities: faculty, support staff, and residents must be paid; conference and classroom space must be included in the hospital plant; and additional equipment and supplies must be purchased. The costs of these activities, known as the direct costs of health professions education, have been measured by standard accounting methods. The direct costs of graduate medical education have been estimated to be between $1 and $3 billion nationwide.

The largest component of direct costs is probably resident stipends and benefits. The average amount that a COTH member hospital spent on resident stipends and benefits in 1983-1984 was $3.2 million, or approximately 4 percent of the average COTH hospital's total operating budget. Thus, the total national expenditure for the direct costs of resident stipends and benefits in the 400 COTH hospitals was approximately $1.3 billion.

In addition to the direct costs of medical education, teaching activities have been associated with other costs that have not been measured directly. These indirect costs can arise from reduced productivity in patient service departments (e.g., treatment takes longer, demands on other staff are greater), increased overhead for such activities as the keeping of medical records, increased complexity of hospital management, and the tendency of residents to provide more services and to order more tests than experienced licensed physicians.

In addition, there are other factors that may contribute to the cost differences between teaching and non-teaching hospitals which have not been measured. These factors, which are also associated with the presence of medical education, may include patients who are more severely ill because the diversity and sophistication of the services offered in teaching hospitals attracts cases of greater complexity, more sophisticated and expensive medical technology (with perhaps the added cost of "idle" time or "standby" capacity for infrequently used services), and higher and more specialized staffing levels.

The indirect costs of health professions education in teaching hospitals are difficult to separate from total operating costs and to quantify because patients are being treated and students are being trained through the same patient care activities. Although data show that teaching hospitals have costs per admission that are twice as high (100 percent higher) as those in non-teaching hospitals, few studies have attempted to account for this difference. The direct costs of health professions education programs account for only approximately 10 percent of the difference in costs between teaching and non-teaching hospitals. Thus, approximately 90 percent of the difference remains to be accounted for. Due to the limited analyses of indirect medical education costs, it is unclear how much of the remainder is attributable to each of the factors mentioned.

Using broad estimates from several sources, the total national cost to hospitals of their health professions education activities ranges from $4 to $9 billion, with $1 to $3 billion estimated for direct costs and $3 to $6 billion for indirect costs. These amounts represent approximately one percent to two and one-half percent of the $355 billion spent nationally for health in 1983.

IV. MEDICARE PAYMENTS FOR HEALTH PROFESSIONS EDUCATION IN HOSPITALS

A. Overview of Payment Sources for Health Professions Education

A variety of sources exist for financing health professions education. For undergraduate medical education, support is available for student assistance, primarily through Federal loans and loan guarantees, and Federal and private scholarships. Medical schools receive financial support from Federal research awards, State and local government appropriations, the professional fees generated by faculty members from their patient care activities, and Federal grants available under the Public Health Service Act for special education and training programs.

At the graduate medical education level, teaching hospitals receive support for health professions education programs primarily through patient care revenues received from such payers as Medicare, Medicaid, and private health plans. For example, according to 1983-1984 data on COTH member hospitals (excluding Veterans Administration hospitals), 81 percent of the funds for residency stipends and fringe benefits were derived from patient care revenues. Other sources included State appropriations earmarked for residency expenses (5 percent), Veterans Administration appropriations (2 percent), medical school/university funds (2 percent), municipal appropriations earmarked for residency expenses (1 percent), and physician fee revenues (1 percent). Foundation grants and voluntary agencies, NIH, other Federal agencies, endowment income, and other sources of support made up the remaining 8 percent of total residency support in teaching hospitals. See the Appendix of this paper for a further discussion of selected sources of funding for health professions education including the Medicaid program, private payers, Titles VII and VIII of the Public Health Service Act, and faculty practice plans.

Support of health professions training in hospitals through patient care revenues has historically been considered appropriate since such training is produced in conjunction with patient care. Teaching hospitals have routinely included the costs of these training programs along with their other expenses in determining their total costs of producing hospital services and in setting their charges for services. Generally, these costs have also been included in patient care payments made by organizations that pay for hospital services (known as third-party payers), including Medicare, Medicaid, Blue Cross, and the commercial health insurers. Health professions education in hospitals has thus been subsidized by the third-party payers, who obtain their funds for patient care payments from various sources, including employer/employee payroll taxes (Medicare), Federal and State tax revenues (Medicaid), and employer/enrollee premium payments (Blue Cross and commercial insurers). As Medicare is the single largest payer for hospital care, it also contributes the greatest proportion of funding for health professions education.

B. Medicare Payments for Health Professions Education in Hospitals

Since its inception, the Medicare program has recognized in its reimbursements to hospitals certain expenses associated with the operation of approved health professions education programs. Although not required by law, congressional intent indicated that the Medicare program should pay its share of the net cost of education activities conducted in hospitals until the community undertakes to cover these costs in some other way.

Medicare regulations (CFR, Title 42, Sec. 405.421) indicate that a provider's (e.g., a hospital's) allowable costs for purposes of Medicare reimbursement may include the net cost of approved educational activities. Net cost is defined as a provider's total direct and overhead costs of approved educational activities (including trainee stipends, compensation of faculty and other direct and overhead costs, minus revenues the provider receives from tuition).

Approved education activities are defined by regulation as formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law; where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity. Approved programs include medical, osteopathic, dental, and podiatry internships and residency programs, and recognized professional and paramedical educational and training programs including cytotechnology, dietetic internships, hospital administration residencies, inhalation therapy, medical records, medical technology, nurse anesthetists, professional nursing, practical nursing, occupational therapy, pharmacy residencies, physical therapy, and x-ray technology. The regulations provide that appropriate consideration will be given by the intermediary and the Health Care Financing Administration to the costs of other educational programs not included in this list.

Medicare's share of hospitals' net costs of approved education activities is generally reimbursed under Part A (Hospital Insurance) of the program. It should be noted, however, that hospitals' costs of intern and resident services where the intern or resident is not in an approved program are reimbursable on a cost basis under Part B (Supplementary Medical Insurance) of the Medicare program. Intern and resident costs for services provided to hospital outpatients are also reimbursable to the hospital on a cost basis under Part B. In both these instances, the hospital would be paid on the basis of 80 percent of the cost of services rendered to Medicare beneficiaries, after recognition of the beneficiary's deductible ($75 per year). Information on the extent to which reimbursement is made under Part B of the program is not readily available.

1. Payment Under Cost-Based Reimbursement. When the Medicare program began in 1966, Medicare paid its proportional share of a hospital's health professions education costs together with other allowable costs under Medicare's cost-based method of reimbursement. Over the years, as the Medicare program began to establish limits on the amounts it paid to hospitals, the costs of medical education received special consideration.

Under authority contained in Section 223 of the Social Security Amendments of 1972, the Department of Health and Human Services (then the Department of Health, Education and Welfare) began in 1974 to establish annual cost limits on reimbursement of certain routine hospital costs (primarily, the costs of room, board, and routine nursing care). The higher routine costs of hospitals with significant medical education activities were recognized by the Medicare program in 1975 when an exception to the routine hospital cost limits was allowed if a hospital could demonstrate that it exceeded its cost limits because of the costs of its educational activities, to the extent that such costs were atypical compared to those of other similar hospitals.

Recognition was made of medical education costs, effective with hospital cost reporting periods which began July 1, 1979, when the direct costs of approved medical education programs were excluded from the routine costs subject to the Medicare hospital cost limits. The direct medical education costs were excluded so that the basis on which the cost limits were applied in teaching and non-teaching hospitals would be more nearly comparable.

On April 1, 1980, the Department proposed that an additional adjustment for the indirect costs of medical education programs be made to Medicare's hospital routine cost limits. The proposed regulations stated that:

> Generally, hospitals with approved graduate medical education programs incur higher per diem operating costs than non-teaching hospitals of similar bed size and geographic location . . . .

> We believe these increases in per diem cost occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. . . . To prevent a disproportionate number of teaching hospitals from being adversely affected by the limits, we have, in the proposed schedule, provided an automatic adjustment for the costs generated by approved medical education programs. Based on the data we used to derive the proposed limits, we have estimated that a hospital's general inpatient routine operating costs may be expected to increase by a factor of .047 (4.7 percent) for each increase of .1 (above zero) in the ratio of its full-time equivalent (FTE) interns and residents (in approved programs) to its number of beds. 3/

It should be noted that the proposed regulations stated that to obtain this adjustment, a teaching hospital would not be required to identify explicitly the costs for which the adjustment was being made. Instead, the hospital would be required to report only its number of full-time equivalent interns and residents in approved programs (i.e., those employed more than 35 hours or more per week and one-half of those employed less than 35 hours per week in the hospital) which, together with the hospital's bed size, would be used to compute the percentage by which the hospital's reimbursement limit would be increased. This medical education adjustment, which later became known as the indirect medical education adjustment, became effective for hospital cost reporting periods which began on July 1, 1980.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) made certain changes in the hospital routine cost limits, including expansion of the limits to cover total inpatient operating costs (not just routine costs) so that ancillary and special care unit costs were included. Because more of a hospital's costs were now included under the limits, the

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3/ Federal Register, April 1, 1980, p. 21584.

limits effective for hospital cost reporting periods beginning on October 1, 1982, included an increase in the percentage amount of the indirect medical education adjustment from 4.7 percent to 6.06 percent.

TEFRA also created a new ceiling on the allowable annual rate of increase in total inpatient operating costs per case for inpatient hospital services. As with the hospital cost limits, these new rate-of-increase limits excluded the direct costs of approved health professions education programs.

2. Payment Under the Prospective Payment System. Title VI of the Social Security Amendments of 1983 (P.L. 98-21) established a new method of hospital payment by the Medicare program, known as the Prospective Payment System (PPS). Effective for hospital cost reporting periods that began on or after October 1, 1983, the Medicare program has been paying hospitals, with certain exceptions, according to predetermined rates for each of 468 Diagnosis Related Groups (DRGs), rather than on a cost basis. The prospective payment legislation and regulations, however, continue to provide for special treatment of direct and indirect medical education costs.

a. Direct medical education costs under PPS. The direct costs of medical education in hospitals are excluded by law from the Prospective Payment System and are paid for separately on the basis of reasonable costs. In its December 1982 report to Congress proposing a hospital prospective payment system for Medicare, the Department favored excluding the direct costs of approved medical education programs from the prospective rates and reimbursing them on the basis of reasonable costs. As stated in the report: "This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care." 4/

b. Indirect medical education costs under PPS. P.L. 98-21 requires that additional payments be made to hospitals for the indirect costs of medical education, computed in the same manner as the adjustment for indirect medical education costs was calculated under the Medicare hospital cost limits, except that the educational adjustment factor would be doubled. The Senate Finance Committee report on the Social Security Act Amendments of 1983 indicates that the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching institutions. The report also states:

> This adjustment is provided in the light of doubts (explicitly acknowledged by the Secretary in his recent report to Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process.
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> The committee emphasizes its views that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the postgraduate medical education of physicians which the medicare

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4/ U.S. Department of Health and Human Services. Report to Congress. Hospital Prospective Payment for Medicare. Dec. 1982, pp. 47-48.

program has historically recognized as worthy of support under the reimbursement system. 5/

As required by law, the Secretary computed the indirect adjustment factor in the same manner as had been done previously; however, the Secretary used more recent data than had been used in making the computation under TEFRA. As a result, the payment for indirect medical education costs equals 11.59 percent (not 12.12 percent, double the previous 6.06 adjustment factor) of the Federal portion of a hospital's prospective payment for every 0.1 in the hospital's ratio of full-time equivalent (FTE) interns and residents to its bed size. Regulations defined the number of FTE interns and residents to be the sum of the number of interns and residents employed by the hospital for 35 hours or more per week, plus one-half of the number of interns and residents working less than 35 hours per week. For cost reporting periods beginning on or after October 1, 1984, interns and residents are not required to be employees of the hospital in order for the hospital to qualify for the indirect medical education adjustment. Hospitals are now required to document each intern or resident providing services at the facility by name and Social Security number and the number of hours the intern or resident works at that hospital.

5/ U.S. Congress. Senate. Social Security Amendments of 1983. Report to Accompany S. 1. March 11, 1983. Washington, U.S. Govt. Print. Off., 1983. (98th Congress, 1st Session. Senate Rept. No. 98-23), p. 52.

3. Cost to Medicare of Health Professions Education in Hospitals. Estimates from the Health Care Financing Administration presented at the April 3, 1985, hearing on Federal support for medical education held by the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, indicate that Medicare expenditures for health professions education will total approximately $2.7 billion in FY86, $1.3 billion for direct costs and $1.4 billion for indirect costs. Medicare is the single largest payer for health professions education in hospitals, contributing approximately one-third of the total.

Health Care Financing Administration data from the 1981 Medicare hospital cost reports trended forward to FY86 indicate that approximately 70 percent of Medicare payments for direct medical education costs are for intern and resident programs, 20 percent for nursing programs, and 10 percent for other programs.

V. SUMMARY OF S. 1158

S. 1158, introduced by Senators Dole, Durenberger, and Bentsen on May 16, 1985, amends Section 1861(v)(1) of the Social Security Act with respect to Medicare's payments to hospitals for the direct costs of approved educational activities. The bill consists of four major provisions.

A. One Year Freeze

Medicare's payments to hospitals for the direct costs of approved educational activities would be frozen for one year. For each hospital, the amount recognized as reasonable for such costs in the "freeze accounting period" (i.e., the hospital's first cost accounting period which begins on or after July 1, 1985) could not exceed the amount recognized as reasonable during the "base accounting period" (i.e., the hospital's most recent cost accounting period ending prior to July 1, 1985). Any salary or wage increases and any cost center shifting or reallocation implemented after May 1, 1985, would be disregarded. For each hospital whose cost accounting period does not begin on July 1, the Secretary would be required to increase such hospital's base amount for educational activities by an appropriate factor to reflect general increases in the costs of approved educational activities which occurred between the end of the hospital's base accounting period and the beginning of its freeze accounting period, disregarding any increases in salary or wages after May 1, 1985.

B. Residency Limitation

A limit would be placed on the number of years of residency training which would be financed by the Medicare program. Beginning July 1, 1986, the Medicare program would not recognize hospital costs incurred for an intern or resident whose training exceeds the lesser of (a) 5 years, or (b) the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in that intern or resident's chosen specialty. After July 1, 1989, if the number of years required for training in a particular specialty has changed, the Secretary could, after consultation with the Accreditation Council on Graduate Medical Education, modify the number of years for which Medicare would make payment, not to exceed 5 years.

C. Foreign Medical School Limitation

The Medicare program would no longer reimburse hospitals for the training costs of non-U.S. citizens who are graduates of foreign medical schools. Beginning July 1, 1986, the Medicare program would not recognize hospital costs incurred for interns and residents who are neither graduates of an accredited school of medicine (or accredited school of osteopathy, dentistry, or podiatry) located in the United States or Canada nor a citizen of the United States or Canada.

D. Required Studies

The bill requires that two studies be undertaken. The Secretary of Health and Human Services would be required to study approved educational activities related to nursing and other health professions which are paid for by the Medicare program, and to report the study findings to Congress prior to December 31, 1986. This study should identify the types and numbers of such programs and the number of students supported or trained under each program; the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

The second study required by the bill, to be conducted by the Comptroller General and reported to Congress prior to December 31, 1986, would be a study of the difference between the amounts paid by the Medicare program for inpatients in teaching hospitals and for comparable inpatients in non-teaching hospitals. This study must identify the components of such payments (including inpatient hospital services, physicians' services, capital costs, and direct and indirect teaching costs) and must, to the extent feasible, account for any differences between the amounts of the payment components in teaching and non-teaching settings. The study must, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and payments between teaching and non-teaching settings.

APPENDIX--OTHER SOURCES OF FUNDING FOR HEALTH PROFESSIONS EDUCATION

A. Medicaid

Medicaid is a federally aided, State-operated and administered program of medical assistance for low-income persons. Until the passage of P.L. 97-35 (the Omnibus Budget Reconciliation Act of 1981), States were required to reimburse hospitals on a reasonable cost basis as defined by Medicare. Under reasonable cost reimbursement, the direct and indirect costs of health education programs were included by hospitals in their total reasonable costs, which were then reimbursed by the State Medicaid programs for services provided to Medicaid recipients.

P.L. 97-35 gave States considerable leeway in establishing the method and level of hospital reimbursement of their choice, within certain broad Federal requirements. Approximately half the States are still using the former reasonable cost-based method of reimbursing hospitals or a variation derived from reasonable costs as formerly defined by Medicare. Although no studies exist on Medicaid payments for health professions education costs, presumably in these States the costs to hospitals of health professions education programs are being reimbursed either as a reasonable cost or as a component of the base on which a variation of reasonable cost reimbursement is built.

Other States have established alternative Medicaid hospital reimbursement systems, including prospective payment systems which apply to all payers for hospital care in the State (Maryland, Massachusetts, New Jersey, and New York), prospective payment systems using diagnosis related groups (Michigan, Ohio, Pennsylvania, and Utah), and other types of hospital payment systems, including contracting with individual hospitals (Arizona and California). Some of these systems specify how medical education costs are to be treated. In general, it appears that direct medical education costs are either passed through and reimbursed on a reasonable cost basis or they are included in a per diem or per admission rate paid to the hospital. The indirect costs are generally not treated separately but are implicitly included in the total rate paid to a hospital.

The Health Care Financing Administration has indicated that a rough estimate of total FY86 Medicaid payments for direct medical education is $400 million of which the Federal share would be $250 million. No estimates are available on Medicaid payments for indirect medical education.

B. Private Payers

Since teaching hospitals have historically included the costs of health professions education in their total costs and their charges for patient care, the private payers for hospital services (including Blue Cross, commercial health insurers, prepaid health plans, and private paying patients) have traditionally financed such activities through the payments they make for patient care.

The Blue Cross and Blue Shield Association's 1978 Policy Statement on Payment to Health Care Institutions states that ". . . the cost of community services, such as research and education, should be borne primarily by the community with participation by purchasers occurring only after negotiation." Since medical education benefits society as a whole, the costs associated with medical education are considered the responsibility of the community. The Blue Cross plans generally are expected to obtain medical services for their subscribers at the best possible price. Additional costs above those required to pay for necessary and reasonable medical services are to be paid only after negotiation with the parties involved. However, historically, Blue Cross plans have paid for health professions education costs in the context of paying hospitals their costs or charges for patient care services.

The higher cost of care at teaching hospitals compared to non-teaching hospitals puts them at a disadvantage as various private payers begin to make changes in their payment methods in order to control costs. Such payment changes include paying a prospectively-established fixed rate for patient care, and negotiating contracts with hospitals offering a lower price than their competitors (i.e., a preferred provider organization, or PPO). The higher costs of teaching hospitals may mean that under fixed-price payment systems they will not be paid as large a percentage of their costs as will lower-cost non-teaching hospitals. Or it may mean that under negotiated payment schemes, teaching hospitals will not be able to compete with lower-cost non-teaching hospitals for contracts.

C. Title VII of the Public Health Service Act (Health Professions Education)

Since its first authorization 22 years ago, support under Title VII of the Public Health Service Act has shifted from its original emphasis on increasing, in the aggregate, the nation's supply of health manpower toward directing available support to programs which are intended to address specific problems, such as the geographic and specialty maldistribution of health personnel. Today Title VII funds, among other things, a number of special purpose projects, including primary care training programs; programs to provide training opportunities for students in underserved areas that are geographically removed from the main site of a health professions school (the Area Health Education Center program); a variety of curriculum development projects, including geriatric training projects; public health and health administration training; and programs to identify, recruit, and enroll minority and economically disadvantaged students wishing to pursue health careers.

One of the major areas of Title VII support in recent years has been primary care training, with assistance provided for (1) the establishment of family medicine departments in medical schools; (2) residency training programs in schools and hospitals for family medicine and general dentistry; and (3) residency training programs in schools and hospitals for general internal medicine and pediatrics. Of the $143 million appropriated for Title VII programs in FY 1985, $62 million, or 43 percent, was provided for these three programs. According to the Bureau of Health Professions in the Department of Health and Human Services, a breakdown of grants made in FY 1984 to schools and hospitals under the latter two of these programs shows that, for family medicine residency training, hospitals received $9.4 million (average award $133,372) and schools (medical and oteopathic) received $10.3 million (average award $117,571). For general internal medicine and pediatrics training in FY 1984, hospitals received $2.7 million (average award $176,733) and schools (medical and osteopathic) received $11.9 million (average award $201,136).

Congress has funded primary care programs in order to encourage training opportunities in such fields as family medicine, internal medicine, and pediatrics. It has been noted that, compared with other specialty training programs, primary care programs receive less revenue from patient care services and research grants and loans and thus have greater difficulty in financing their costs. For the last several years, approximately 39 percent of professionally active M.D.s have been in the primary care specialties of family practice, internal medicine, and pediatrics. In 1982, the ratio of primary care physicians per 100,000 population stood at 74, compared with 117 per 100,000 population for all other medical and surgical specialties. Since 1970, the ratio of primary care physicians per 100,000 population has increased from 56 to 74 in 1982, or by 32 percent. For all other medical and surgical specialties, this ratio has increased from 92 to 117 per 100,000, or by 27 percent.

Additionally, Congress has provided support for a number of programs which are intended to address problems associated with the geographic maldistribution of health professionals. These programs, such as Area Health Education Centers (AHECs) and primary care training programs (including physician assistants training programs), are intended to provide incentives for health professions schools to establish and operate training programs which might ultimately increase the number of health personnel practicing in medically underserved areas. The AHEC program, in part, establishes training opportunities for students in underserved areas that are geographically removed from the main site of the health professions school. In addition, studies have indicated that primary care specialists, especially general family practitioners, tend to establish their practices in medically underserved areas more often than other specialists. Thus, increasing the nation's supply of primary care physicians is one way of improving access to health care in previously unserved or underserved areas.

D. Title VIII of the Public Health Service Act (Nurse Training)

Funding authorized under Title VIII of the Public Health Service Act for nurse training programs has provided Federal support for nursing schools and students since 1964. Congress consolidated and expanded programs of support for nurse education in Title VIII in response to perceived shortages of professional nurses in the country. When originally enacted, Title VIII provided Federal support which was intended principally to increase the aggregate supply of registered nurses in the country. It did so by encouraging nursing schools to increase their enrollments and graduates. In 1964 there were 550,000 registered nurses in the country; today there are approximately 1.6 million.

As supply increased, Federal support for Title VIII has been reduced. In 1980, $100.3 million was appropriated for Title VIII programs. In 1985, $50.3 million was appropriated. In addition, available support has shifted its emphasis from increasing aggregate supply to targeting support on education programs which, among other things, allow nurses to receive advanced degrees and train them for specific roles in the nursing profession.

A 1983 Institute of Medicine study found that, while in the aggregate there is not a significant national shortage of generalist registered nurses, shortages do occur unevenly throughout the nation in different geographic areas, in different health care settings (especially those that serve the economically disadvantaged), within institutions, and in particular areas of specializatin within nursing.

Today, Title VIII supports a special projects program which has among its purposes (1) improving the supply and distribution of nurses in geographic areas, in the various specialties of nursing, and in health care institutions;

(2) recruiting and retaining minorities and economically disadvantaged individuals in schools of nursing; and (3) strengthening curriculum in areas such as geriatric and long-term care, health promotion, and disease prevention.

It also provides support for advanced nurse training programs which train nurses to become educators or clinical specialists, or to serve in administrative or supervisory capacities. Observers have noted that since the establishment of Title VIII, the demand for nurses with advanced degrees has continued to be greater than the ability of schools to prepare nurses of advanced levels to work as educators, clinical specialists, administrators, and supervisors.

Title VIII also provides support for the training of nurse practitioners. Nurse practitioners receive advanced training to provide primary care services without the immediate supervision of a physician and often do so in medically underserved areas. Studies have indicated that nurse practitioners provide cost-effective care and increase the productivity of medical practices.

E. Faculty Practice Plans

Faculty practice plans (also called medical practice plans) are formal agreements among medical school clinical faculty to pool their professional income to augment the budget of the medical school so that these funds can be reallocated for a variety of purposes which in general would enhance the quality of the educational or patient service programs. Membership in practice plans is typically limited to clinical faculty who receive compensation for services to patients and who are full-time faculty at the school. Membership in a practice plan is required of all full-time clinical faculty in nearly all public medical schools and in 80 percent of the private schools.

The major use of practice plan income is to supplement teaching faculty salaries. Fringe benefit packages for faculty are another major use of plan funds. The plans also fund malpractice insurance, professional memberships and dues, and professional travel. Plan funds may also be used for clinical activities including clinical space, nursing and clerical staff, outpatient medical records, supplies, and other clinical support.

The 1984 Council of Teaching Hospitals (COTH) Survey of Housestaff Stipends, Benefits, and Funding (Association of American Medical Colleges) indicates that for 1983-1984, physician fee revenues (i.e., faculty practice plans) were the source of funding for a small percentage (0.6 percent) of the costs of residents' stipends and fringe benefits in COTH hospitals nationwide (excluding Veterans Administration hospitals). However, for clinical fellows (i.e., individuals who have completed residency training in such general areas as internal medicine or pediatrics and continue their training to specialize in fields such as cardiology or gastroenterology), physician fee revenues represented 9 percent of total stipend and fringe benefit support.

II

99TH CONGRESS
1ST SESSION

S. 1158

To amend title XVIII of the Social Security Act with respect to Medicare payments for direct costs of approved educational activities.

IN THE SENATE OF THE UNITED STATES

MAY 16 (legislative day, APRIL 15), 1985

Mr. DOLE (for himself, Mr. DURENBERGER, and Mr. BENTSEN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act with respect to Medicare payments for direct costs of approved educational activities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1861(v)(1) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

"(P) Payments relating to the direct costs of approved educational activities at hospitals shall be made in accordance with the regulations in effect on January 1, 1985, except as follows:

"(i) For a hospital's first cost accounting period which begins on or after July 1, 1985 (the freeze accounting period), the amount of such costs recognized as reasonable by the Secretary shall not exceed the amount so recognized with respect to such hospital for such hospital's most recent cost accounting period ending prior to July 1, 1985 (the base accounting period), disregarding any salary or wage increases, and any cost center shifting or reallocation, implemented after May 1, 1985. If a hospital's cost accounting periods do not begin on July 1, the Secretary shall increase the limit established under the preceding sentence by an appropriate factor to reflect general increases in the costs of approved educational activities which took place between the end of the hospital's base accounting period and the beginning of its freeze accounting period, disregarding any increases in salaries or wages after May 1, 1985.

"(ii) Effective on and after July 1, 1986, the Secretary shall not recognize as reasonable any such costs incurred with respect to any intern or resident-in-training for years in training which exceed the lesser of—

"(I) five years, or

"(II) the minimum number of years of formal training necessary to satisfy the requirements (as specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education) for initial board eligibility in the particular specialty for which such intern or resident-in-training is preparing, or, after July 1, 1989, in the event that the required number of years in training increases, the number of years which the Secretary may specify, after consultation with the Accreditation Council on Graduate Medical Education.

"(iii) Effective on and after July 1, 1986, the Secretary shall not recognize as reasonable any such costs incurred with respect to any intern or resident-in-training who is neither a graduate of an accredited school of medicine (or accredited school of osteopathy, dentistry, or podiatry) located in the United States or Canada, nor a citizen of the United States or Canada.".

(b)(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act. The study shall address—

(A) the types and numbers of such programs, and number of students supported or trained under each program;

(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

(2) The Secretary shall report the results of the study to the Congress prior to December 31, 1986.

(c)(1) The Comptroller General shall conduct a study of the difference between the amounts of payments made under title XVIII of the Social Security Act with respect to inpatients in teaching hospital settings and the amounts of such payments which are made with respect to comparable patients who are treated in a nonteaching hospital setting. Such study shall identify the components of such payments (including payments with respect to inpatient hospital services, physicians' services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any differences between the amounts of the payment components in teaching and nonteaching settings.

(2) In carrying out such study, the Comptroller General may utilize a sample of teaching hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians' services under section 2307(c) of the Deficit Reduction Act of 1984.

(3) The Comptroller General shall report the results of the study to the Congress prior to December 31, 1986.

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Opening Statement of Senator Bob Dole

First, I want to take this opportunity to thank the distinguished Senator from Minnesota for his role in initiating the discussions that have brought us here today. We have clearly benefited from the debate stimulated by his earlier legislative initiative addressing Medicare financing of graduate medical education.

While there can be no question that we have committed ourselves to the task of reducing the Federal deficit, we must do so in a manner that protects those who rely on Medicare for their present and future health care needs. For this reason, I wish to make it clear that the Medicare Program should for the foreseeable future continue its commitment to graduate medical education—which includes the training of physicians, nurses and other allied health personnel.

However, while committed to continuing our role in this important process, we mustn't overlook the need to rethink our methods of funds nor the necessity for reducing our expenditures in a reasonable fashion. It is for these reasons, we introduced S. 1158. It is for these same reasons that we hope to introduce subsequent legislation which addresses indirect medical education expenditures.

Our legislation tries to place some limits on direct medical education expenditures without being overly directive. This Senator does not believe that Medicare funding policy should be used to specifically direct health manpower distribution; however, we cannot afford to ignore the incentives created by an open-ended payment. We believe a limit of 5 years or to the point of board eligibility will encourage the various specialty boards and those responsible for the design of residency programs to examine carefully any move to further lengthen residency programs, while not mandating that any specific changes take place. We believe this to be far more logical than an approach which requires that a specific number in a particular specialty be trained, or cuts off entirely funding for another group. Medicare beneficiaries clearly benefit from a wide range of specialists

The funding of graduate medical education is a complex subject. Numerous issues require our attention. For example, financing reform of institutional costs which result from the presence of a teaching program cannot be isolated from issues surrounding part B reimbursement of supervising faculty. Fiscal and other relationships among teaching hospitals, medical residents, faculty, and medicare beneficiaries must be carefully considered. Any changes in medicare part A must also take into account possible effects on part B. Payment of residents' stipends is a relatively inexpensive form of reimbursement, if we were to alternatively allow billing under Part B, the costs might escalate dramatically. In addition, we must increase our understanding of how our reimbursement effects nursing and other health professions. There are also questions of supply and distribution with respect to these groups.

I am pleased to be joined by both Senator Durenberger and Senator Bentsen in working toward legislation that asserts our commitment to graduate medical education and also contributes to the goal of long term solvency of the Health Insurance Trust Fund.

I extend a welcome to the witnesses who are here to testify before us today. I know you have a great deal to contribute and I look forward to our working together. You represent many viewpoints that will certainly help us to craft a bill that addresses many of our common goals. Thank you for coming.

Opening Statement of Senator Bentsen

Mr. Chairman, I want to thank you for scheduling this hearing on the future of Medicare funding of Graduate Medical Education and S. 1158 in particular. As an original cosponsor of the bill, I am acutely interested in the testimony we will hear today.

Under current law, fiscal year 1986 payments for teaching costs will exceed $2.7 billion, making Medicare the single largest source of health education funding in the country. Accordingly, the Administration's budget proposals are designed to reduce support for teaching costs by approximately $3.5 billion over the next three years could exert a significant degree of influence over the future of health education policy.

It is my hope that S. 1158 will serve as a catalyst to stimulate programmatic as well as budgetary discussions among medical educators, administrators to training programs, Members of Congress and representatives of the Executive Branch. The strengths of this bill include neutrality on the question of manpower, adequate transition time where policy changes are called for, a firm commitment to continued Federal support of medical training, and carefully crafted studies designed to elicit the information necessary to further refine the system in the future. However, modifications to improve the bill may be desirable, and I look forward to learning the witnesses views on several unresolved issues including: alternative sources of funding for residents no longer supported by the Trust Funds, the advisability of permitting residents to bill under Part B, and the anticipated effect of direct payment to residents on the quality and cost of care.

Recognizing that we must reevaluate Federal financial commitments in virtually all areas of expenditure, I am gratified that most of the witnesses who will appear before us today have indicated their willingness to engage in constructive efforts to streamline medical education programs supported by Medicare, including consideration of budgetary reductions.

STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I commend you and our colleagues Senator Dole and Senator Bentsen on the introduction of your legislation which addresses the issue of direct costs of medical education under the Medicare Program.

As members of this subcommittee are well aware, Medicare's financial contribution to graduate medical education is a substantial one. In fiscal year 1985, subsidies for direct medical education costs for resident training alone is projected to be approximately $925 million. The total amount for all the professions covered, including physicians, nurses and allied health care personnel may approach the neighborhood of $1.3 billion.

In a time of rapidly escalating health care costs the federal government must reevaluate its open-ended funding of graduate medical education. While we recognize the significant role federal support of medical education has traditionally played in improving and maintaining the quality of care for Medicare beneficiaries, the time has come to carefully examine the current and future needs of the nation for physicians, and the proper role of the federal government in subsidizing the education of physicians.

The supply of physicians has increased dramatically since 1965 when the Medicare Program began. We now face a growing surplus of medical doctors, perhaps as many as 35,000 by 1990. While we are aware of this increasing surplus, we continue to provide a substantial federal subsidy for the education of physicians; currently over 73,000 residents are being trained in this country with the support of the Medicare program.

I believe we must find a way to continue to encourage young men and women to enter the medical profession but with an eye on the needs of the nation's health care. As a Senator from a rural state, I am very concerned about the shortage of physicians in remote areas of Maine. Rural communities such as Calais, Maine cannot find a physician willing to live in that area and work for what can only be viewed by the medical profession as a very low income, to replace the retiring family practitioner who has served the area for generations.

I believe there is a role for the federal government to play in the support and training of graduate medical students. I also believe that we must carefully examine where the need for physicians is in terms of medical specialties and geographic locations.

I look forward to reviewing the testimony presented at this hearing and to working with my colleagues on the Subcommittee to find an improved system of support for graduate medical education which will better serve the needs of health care of persons in all parts of this country.

Senator DURENBERGER. The hearing will come to order.

Since its inception, Medicare has paid hospitals for its share of the cost of training physicians, nurses, and other health professionals, and in the last few months we have all become familiar with that provision of the 1965 act which reads as follows:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

That comes out of this committee, which accompanied H.R. 6675, the purpose of which was to provide a hospital insurance program for the aged.

Obviously, the Chair of this subcommittee would put the accent on the time elements of the commitment, and it is intended "until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities"—et cetera.

In light of the changing nature of health care delivery, financing, and the Medicare Program, it is an appropriate time to revisit this 20-year-old policy.

I have been joined by Senators Dole and Bentsen in sponsoring a bill, S. 1158, which revises Medicare policy toward the funding of hospital-based clinical training and makes this policy more relevant to current conditions in the health care system.

Today's hearing will focus on the four major issues that S. 1158 raises: the future of Medicare's traditional open-ended reimbursement for its share of the direct cost of hospital-based clinical training; the limitation of Medicare payment to its share of the residency training required for initial board-eligibility; the termination of Medicare payment of the cost of training graduates of foreign medical schools who are not citizens of the United States or Canada; and the reevaluation of Medicare policy toward the support of hospital-based training for nurses and other health professionals.

The witness list for this hearing today is impressive, and it is representative of the array of organizations interested in and knowledgeable about the training of health care professionals and teaching hospitals.

The testimony we hear today will provide solid information upon which the Finance Committee can base its consideration of the proposals included in S. 1158. My colleagues and I are confident that, from what we know of the comments that we are going to hear today and others which we have received, that this committee should have every reason to be able to adopt the proposals of S. 1158 as part of its reconciliation package.

This hearing and S. 1158, however, should not be viewed as an end point in the reform of the financing for medical education. Action on S. 1158 is only part of a process which must go well beyond simply restructuring the Medicare direct medical education expense.

Last October I made my first little contribution to this broader process by introducing the so-called Graduate Medical Education Block Grant bill, S. 3073. This statement is sort of an understatement—the bill received much attention. It laid part of the groundwork for S. 1158.

S. 3073 also generated discussion in the academic medical community concerning not only the future role of Medicare in the financing of graduate medical education, but the implications for graduate medical education and teaching hospitals of the evolving price-competitive medical marketplace.

These discussions, like this consideration of the legislative solution, are continuing, and future hearings of this subcommittee will be required to look at these issues and these proposals for reform which will emerge from this discussion.

It is also important in this atmosphere of reform and redirection that we do not lose sight of the fact that the Federal Government has commitments to help professions' training which reach beyond Medicare.

It is my intention that our policies toward training physicians in the Veterans' Administration hospitals' clinic system, which includes over 7,000 residents, and through the Public Health Service Act, be coordinated with the overall health systems reform which was adopted by the Congress.

These issues will take time to resolve. Action on S. 1158 is only a start. But I should stress for all those concerned that the timetable for reform in America is short.

From my observation of activity around the country, the purchasers of health care are becoming much less willing to assume the additional costs of training, research, and indigent care. They are becoming more interested in committing their patient-service dollars to the specific care for which they subscribe. Hospitals, nonteaching and teaching alike, are responding to these developments by moving to price competition and away from the expectation that all purchasers will agree to pay their posted costs or charges.

This process has not taken hold completely everywhere as yet, but the indications are we are heading into an environment where it will be impossible for teaching hospitals to continue to subsidize training, research, and indigent care missions through patients' third-party payments.

Instead, other more explicit avenues for funding must be found. And inefficient and less essential programs will have to be reduced in size or eliminated.

I hope the witnesses feel free to touch on these issues as well as S. 1158, and I know from their statements they have. And I want to express my appreciation as well as the appreciation of my colleagues to each of you who has taken the time from your busy schedule to come here today.

Before I close, I would also like to take this opportunity to comment briefly on the publication by the Department of Health and Human Services of a number of proposed regulations affecting Medicare spending.

It was apparent from the President's budget message that this administration intended to use the regulatory process for deficit reduction through the Medicare Program. Since January I have stated publicly in a number of forums and in private with administration officials that this use of the regulatory process by the administration was at best inappropriate. Budget policy is the responsibility of the Congress, albeit in consultation with the executive branch and ultimately with the consent of the President.

The fine line between the improper implementation of Medicare policy and actual policymaking is not a difficult one to cross in the area of Medicare. It was my view and the view of Senator Dole and other members of Congress that this line was crossed last August in the controversy over the DRG rate increase for the current fiscal year. The situation may be exacerbated in the cycle for the next fiscal year, regardless of the set of arguments and justifications provided by the Department.

I understand, at a time when the Congress is considering freezes on direct medical education expenses and the DRG rates, that both the Congress and the administration are using similar vehicles to achieve similar goals. But the point remains that the intent of the Congress in providing perogatives to the Department to implement Medicare policy never assumed that it would use the regulatory process to set budget policies without direction from the Congress.

I firmly believe the use of the regulatory process in this particular manner threatens the credibility of the Department of Health and Human Services and its essential role in the continued implementation of health system reform through Medicare. We have one OMB. That's all we need in this place.

It will be difficult for the Congress to continue to give broad perogatives to the Department if this Administration uses these mandates only to meet budget-reduction agendas outside the congressional policymaking process.

System reform in health care is difficult. It is, however, the largest—in dollars—policy reform going on in this country. It is, in fact, a carefully crafted but very informally crafted arrangement between the public sector and the private sector, among financers and providers in both sectors. Trust and commitment are essential elements in the reform process.

The axe has no place in surgery, and HHS–OMB regulatory policy in system reform is bound to be counterproductive.

So, with that, let us head into the Department of HHS. Neither Mr. Desmarais nor Mr. Hatch is responsible for the comments I just made.

Gentlemen, I understand that each of you has separate statements, and that it would be appropriate that you each be permitted the 5 minutes that we have allotted to other witnesses to make your separate statements. We will have brief questions.

I will say at this time to all the other witnesses that we will have to limit your testimonies to 5 minutes each. Your statements are excellent; they will all be made part of the record. I have read practically all of them, and I am sure others will, too. We will try to move through this hearing by 12 or 12:30 today, if we can.

So if we may begin, then, with Dr. Desmarais.

STATEMENT OF HENRY DESMARAIS, M.D., DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, HEALTH CARE FINANCING ADMINISTRATION

Dr. **Desmarais.** Mr. Chairman, I am pleased to be here a second time to discuss the subject of medical education. This morning I plan to provide a very brief overview of how Medicare currently reimburses for medical education costs, to describe the proposed changes in this area included in the President's fiscal year 1986 budget, and to present the administration's views on S. 1158.

We look forward to continuing a dialog with this committee that will result in constructive reform of Medicare's financing of graduate medical education.

In fiscal year 1983 more than 1,300 hospitals were engaged in educational activities operated directly by the hospitals, including training programs for interns and residents, nurses, and a variety of paramedical specialties.

Medicare's policy with respect to payment for medical education goes back to the origins of the program. Clearly the Congress believed that support for medical education would become a community expense and, until that time, would be supported by the Federal Government. Of course, the quote that you cited in your opening comments is relevant here.

Medicare reimbursement for medical education costs is accomplished in two ways. First, there are direct medical education costs, which include the stipends of trainees, compensation of teachers, and classroom and a variety of associated overhead costs. These are paid for on a cost related basis and are separate from the hospital prospective payment system.

In fiscal year 1986, assuming no change in policy, we estimate that Medicare expenditures for direct medical education would be approximately $1.3 billion.

The second component of medical education are the indirect costs. The presence of medical education programs and their trainees generates additional costs for support services and other activities that cannot be separated easily from patient care costs. These indirect costs may be due to larger volumes of lab tests and similar services that are ordered by physicians in training, to a greater complexity of cases that occur in teaching hospitals which are not captured by the current case-mix system, or to simply the inefficiency of the educational setting.

When limits were placed on hospital routine operating costs and later on costs per case, a formula was developed to determine an adjustment for indirect medical education costs of teaching hospitals. The formula was derived from an analysis of the relationship of costs per case to the ratio of interns and residents to hospital beds.

When the prospective payment legislation was adopted by the Congress, the Congress chose to double this empirically based factor which had been used to adjust the payment limits under cost reimbursement. The result of this is that teaching hospitals now receive an 11.59-percent increase in the Federal portion of the prospective payment rate for every one-tenth increase in the ratio of interns and residents to beds.

Again, assuming no change in policy, we estimate that in fiscal year 1986 the Medicare expenditures for indirect medical education would equal about $1.4 billion.

As you have noted in your opening remarks, the President's budget does include a variety of proposals in this area. The first is a regulatory change to limit payments for direct medical education, and the second is a statutory proposal to eliminate the doubling of the indirect medical education adjustment.

On the subject of the first, the direct medical education change, we note that a surplus of about 35,000 physicians is expected by 1990, as projected by the Public Health Service. In light of this surplus and the fact that over two-thirds of the functions in the President's budget will experience a real decline in spending, it is hard to justify the continuation of a blank check policy for direct medical education. Toward this end, therefore, on May 21 we issued a proposed rule which would limit Medicare reimbursement for direct medical education costs for cost-reporting periods beginning on or after July 1, 1985 but before July 1, 1986. The limit would be tied to Medicare utilization changes and would be based on the lesser of the allowable costs during that cost-reporting period or the base year. Our base year would be the provider's cost-reporting period beginning during fiscal year 1984, the first year of the prospective payment system. We expect to save $145 million through this proposal.

For indirect medical education, our proposal would eliminate the doubling of the factor that had been mandated in the Social Security Amendments of 1983. This would result in Medicare savings of $695 million in fiscal year 1986 and a total of $6.6 billion through fiscal year 1990.

We turn now to our comments regarding S. 1158, the bill which you, Mr. Chairman, have sponsored along with Senators Dole and Bentsen. Clearly that bill acknowledges the need to reform the way Medicare currently pays for direct medical education. We have similar objectives in this area, and we are pleased to share with you our constructive comments regarding this bill.

S. 1158, like the administration's proposal, would freeze payments for direct medical education for hospital cost reporting periods beginning July 1, 1985; although, S. 1158 uses a different base period. Furthermore, beginning July 1, 1986, the bill would reduce payments for direct medical education by limiting support for residents to the minimum number of years to become board-certified or to a maximum of 5 years.

The administration's present approach is to limit spending and to let the medical community, rather than the Federal Government, determine how best to utilize the funds. We believe that studies on items such as geographical distribution of residents, salary level of those residents, and supply of specialties and subspecialties would provide the Federal Government with a better understanding of the graduate medical education needs of the Medicare population.

S. 1158 also proposes to eliminate support for noncitizen foreign medical graduates. We support a policy of Medicare payment for medical graduates who have demonstrated an ability to practice quality medicine by passing the tests necessary to become licensed and who have either achieved a permanent residency status or are U.S. citizens.

There are also a number of administrative issues that need to be clarified, and we would be pleased to work with the committee in this regard. For example:

Further examination of the effects of the bill on the savings to Medicare are necessary.

Second, the bill could result in a substantial increase in reporting requirements. Information regarding the locus of medical school training, the citizenship status, the status of residency training, and the career plans of 75,000 residents would need to be collected in some manner.

HCFA would have to develop an update factor for hospitals whose cost-reporting periods do not begin on July 1, 1985. This, too, would require a study in order to determine the appropriate index factor for resident salaries and other costs.

A 5-year limit on payment for residency training presents some difficulties in implementation. For example, residents frequently move from place to place during the course of their training and others change specialty in mid-course—for example, going from internal medicine to pathology. Furthermore, would entrance into a subspecialty after qualification in a basic specialty begin the 5-year clock again? All of these questions demonstrate the complex nature of residency programs and indicate the merit of further analysis.

Clear authority would need to be granted to the Secretary to develop methodologies to determine how to pay for overhead costs associated with residents who are no longer receiving Medicare support.

Furthermore, to achieve the cost savings for the bill, the residents excluded from Medicare payment under part A of the program would have to be precluded from billings for services under part B.

Finally, we note that some hospitals presently depend disproportionately on foreign medical graduates. In addition, in some specialties, foreign national foreign medical graduates hold a substantial number of residencies.

In conclusion, I wish to underscore our shared desire to take positive action now to limit the current open-ended funding of medical education, and together we believe we can craft a solution that will not cause grave disruption in the medical education community.

That concludes my prepared remarks.

Senator **Durenberger**. Thank you, Doctor.

I was only momentarily tempted to take 3 minutes off your statement, Mr. Hatch, but I thought it was important that everybody hear Henry's testimony. You may proceed.

[The prepared statement of Dr. Desmarais follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

HENRY DESMARAIS, M.D.

DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT
AND COVERAGE

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
FINANCE COMMITTEE

UNITED STATES SENATE

JUNE 3, 1985

MR. CHAIRMAN, I AM PLEASED TO BE HERE TODAY TO PROVIDE AN OVERVIEW OF HOW MEDICARE CURRENTLY REIMBURSES HOSPITALS FOR MEDICAL EDUCATION COSTS, TO DESCRIBE THE CHANGES WE HAVE PROPOSED IN THIS AREA IN THE FY 1986 BUDGET AND TO PRESENT THE ADMINISTRATION'S VIEWS IN REGARD TO S.1158. WE LOOK FORWARD TO CONTINUING A DIALOGUE WITH THIS COMMITTEE THAT WILL RESULT IN CONSTRUCTIVE REFORM OF MEDICARE'S FINANCING OF GRADUATE MEDICAL EDUCATION.

WE BELIEVE THAT MEDICARE'S CURRENT POLICY OF BASING ITS REIMBURSEMENT ON 100 PERCENT OF DIRECT COSTS OF APPROVED EDUCATIONAL ACTIVITIES DOES NOT ENCOURAGE COST CONSCIOUSNESS AND RESULTS IN PAYMENT FOR SOME COSTS THAT ARE NOT NECESSARY IN THE EFFICIENT DELIVERY OF HEALTH SERVICES TO MEDICARE BENEFICIARIES.

BACKGROUND

IN FY 1983, MORE THAN 1,300 HOSPITALS WERE ENGAGED IN EDUCATIONAL ACTIVITIES OPERATED DIRECTLY BY THE HOSPITALS INCLUDING TRAINING PROGRAMS FOR INTERNS AND RESIDENTS, NURSES AND VARIOUS PARAMEDICAL SPECIALTIES. ABOUT THREE-QUARTERS OF THE FINANCING FOR THESE PROGRAMS COMES FROM PATIENT CARE REVENUES RECEIVED FROM MEDICARE, MEDICAID AND OTHER THIRD PARTY PAYORS. ASSUMING THAT PAYMENTS FOR MEDICAL EDUCATION COSTS ARE ROUGHLY IN PROPORTION TO REIMBURSEMENTS FOR MEDICAL

SERVICES. MEDICARE CONTRIBUTES THE LARGEST AMOUNT TOWARD MEDICAL EDUCATION COSTS OF ALL PAYORS. APPROXIMATELY ONE-THIRD. THUS, MEDICARE HAS A MAJOR IMPACT ON MEDICAL EDUCATION AND THROUGH ITS OPEN-ENDED, COST-BASED SYSTEM OF REIMBURSEMENT FOR THESE ACTIVITIES, MAY HAVE CONTRIBUTED INADVERTENTLY TO THE CURRENT SURPLUS IN THE SUPPLY OF PHYSICIANS.

MEDICARE'S POLICY IN REGARD TO PAYMENT FOR MEDICAL EDUCATION GOES BACK TO THE BEGINNING OF THE PROGRAM. THE COMMITTEE REPORTS THAT ACCOMPANIED THE PASSAGE OF MEDICARE IN 1965 VIEWED SUPPORT FOR MEDICAL EDUCATION AS A COMMUNITY EXPENSE THAT WOULD BE SUPPORTED BY THE FEDERAL GOVERNMENT ONLY TEMPORARILY. IT STATED THAT, "UNTIL THE COMMUNITY UNDERTAKES TO BEAR SUCH EDUCATION COSTS IN SOME OTHER WAY, THAT A PART OF THE NET COST OF SUCH ACTIVITIES . . . SHOULD BE CONSIDERED AS AN ELEMENT IN THE COST OF PATIENT CARE, TO BE BORNE TO AN APPROPRIATE EXTENT BY THE HOSPITAL INSURANCE PROGRAM."

THE TERM "MEDICAL EDUCATION COSTS" ENCOMPASSES NOT ONLY THOSE COSTS ASSOCIATED WITH PROGRAMS TRAINING PHYSICIANS BUT ALSO A RANGE OF HEALTH PROFESSIONAL AND PARAPROFESSIONAL TRAINING PROGRAMS. MEDICARE REGULATIONS SPECIFICALLY RECOGNIZE 13 APPROVED PROGRAMS IN ADDITION TO GRADUATE MEDICAL EDUCATION PROGRAMS, RANGING FROM NURSING AND CYTOTECHNOLOGY TO MEDICAL RECORDS TRAINING.

MEDICARE REIMBURSEMENT FOR MEDICAL EDUCATION COSTS IS COMPOSED OF TWO SEPARATE PIECES, DIRECT COSTS AND INDIRECT COSTS, WHICH ARE REIMBURSED IN DIFFERENT WAYS.

MEDICARE DIRECT MEDICAL EDUCATION PAYMENTS

DIRECT MEDICAL EDUCATION COSTS ARE THE MORE TANGIBLE COSTS SUCH AS STIPENDS OF TRAINEES, COMPENSATION OF TEACHERS, AND CLASSROOM AND ASSOCIATED OVERHEAD. THESE DIRECT COSTS ARE NORMALLY ALLOCATED TO SPECIAL COST CENTERS UNDER MEDICARE'S COST REPORTING SYSTEM. MEDICARE'S SHARE OF THESE COSTS IS DETERMINED USING THE SAME PROCEDURES THAT WERE DEVELOPED FOR COST-BASED REIMBURSEMENT OF OTHER PATIENT CARE COSTS.

WHEN DEVELOPING A PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITALS, CONGRESS APPROVED CONTINUATION OF PAYMENT FOR DIRECT MEDICAL EDUCATION COSTS ON A COST-RELATED BASIS, SEPARATE FROM THE DIAGNOSIS-RELATED GROUP (DRG) PAYMENT PER CASE. ALLOWANCE OF THIS PASS-THROUGH RECOGNIZES THAT THE OPERATION OF THESE PROGRAMS AND THE ACCOMPANYING COSTS ARE CONCENTRATED IN A LIMITED NUMBER OF HOSPITALS (1300). IN FY 1986, ASSUMING NO CHANGE IN POLICY, WE ESTIMATE THAT MEDICARE EXPENDITURES FOR DIRECT MEDICAL EDUCATION WOULD BE APPROXIMATELY $1.3 BILLION.

MEDICARE INDIRECT MEDICAL EDUCATION PAYMENTS

THE PRESENCE OF MEDICAL EDUCATION PROGRAMS AND THEIR TRAINEES ALSO GENERATES ADDITIONAL COSTS FOR SUPPORT SERVICES AND OTHER ACTIVITIES THAT CANNOT BE SEPARATED EASILY FROM PATIENT CARE COSTS. THESE INDIRECT COSTS MAY INCLUDE INCREASED DEPARTMENTAL OVERHEAD AND THE HIGHER COST OF TREATING PATIENTS DUE TO A LARGER RELATIVE VOLUME OF LABORATORY TESTS AND SIMILAR SERVICES. SOME BELIEVE THAT THIS LARGER VOLUME OF TESTS AND SERVICES MAY BE DUE, IN PART, TO A GREATER COMPLEXITY OF CASES IN TEACHING HOSPITALS NOT CAPTURED BY OUR CASE-MIX MEASURE.

PRIOR TO PPS, UNDER THE ORIGINAL COST-BASED REIMBURSEMENT SYSTEM, THERE WAS NO REASON TO DETERMINE THE MAGNITUDE OF THESE INDIRECT COSTS SINCE THERE WERE VIRTUALLY NO LIMITS ON THE AMOUNT OF THE COSTS THAT WOULD BE REIMBURSED. HOWEVER, WHEN LIMITS WERE PLACED ON ROUTINE OPERATING COSTS AND LATER ON COSTS PER CASE, A FORMULA WAS DEVELOPED TO DETERMINE AN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION COSTS TO THE REIMBURSEMENT LIMITS FOR TEACHING HOSPITALS. THE FORMULA WAS DERIVED FROM AN ANALYSIS OF THE RELATIONSHIP OF COSTS PER CASE TO THE RATIO OF INTERNS AND RESIDENTS TO HOSPITAL BEDS.

IN DEVELOPING THE PROSPECTIVE PAYMENT LEGISLATION, CONGRESS DETERMINED THAT AN AMOUNT, IN ADDITION TO THE OTHERWISE APPLICABLE PROSPECTIVE PAYMENT RATE, SHOULD BE PAYABLE FOR INDIRECT MEDICAL EDUCATION COSTS. IN THE LEGISLATION, THE EMPIRICALLY-BASED FACTOR USED TO ADJUST THE PAYMENT LIMITS UNDER COST REIMBURSEMENT, WAS DOUBLED. AS A RESULT, TEACHING HOSPITALS NOW RECEIVE AN 11.59 PERCENT INCREASE IN THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE FOR EVERY ONE-TENTH OF THE HOSPITAL'S RATIO OF INTERNS AND RESIDENTS TO BEDS.

IN FY 1986, ASSUMING NO CHANGE IN POLICY, WE ESTIMATE THAT MEDICARE EXPENDITURES FOR INDIRECT MEDICAL EDUCATION WOULD EQUAL APPROXIMATELY $1.4 BILLION. THIS EXCLUDES COSTS ASSOCIATED WITH THE HOSPITAL SPECIFIC PORTION OF THE PPS PAYMENT. IN FY 1987, WHEN THE PPS RATE IS BASED ENTIRELY ON THE FEDERAL RATE, PAYMENTS FOR INDIRECT MEDICAL EDUCATION WOULD BE ABOUT $2.2 BILLION.

PROPOSED CHANGES TO MEDICARE REIMBURSEMENT FOR MEDICAL EDUCATION

THE PRESIDENT'S FY 1986 BUDGET PROPOSAL WOULD MAKE CHANGES IN THE WAY MEDICARE PAYS FOR MEDICAL EDUCATION. FIRST, WE ARE PROPOSING A REGULATORY CHANGE TO LIMIT PAYMENTS FOR DIRECT MEDICAL EDUCATION. SECOND, WE ARE PROPOSING A STATUTORY CHANGE TO ELIMINATE THE DOUBLING OF THE INDIRECT MEDICAL EDUCATION FACTOR.

THE INITIAL DECISION TO HAVE MEDICARE PAY FOR MEDICAL EDUCATION COSTS WAS MADE AT A TIME WHEN THERE WAS A SHORTAGE OF PHYSICIANS AND NURSES. TODAY, A SURPLUS OF 35,000 PHYSICIANS BY 1990 IS PROJECTED BY THE PUBLIC HEALTH SERVICE. SIMILARLY, WHILE THERE IS NOT A SURPLUS OF NURSES, THE SUPPLY OF REGISTERED NURSES INCREASED BY 83 PERCENT BETWEEN 1970 AND 1982.

IN LIGHT OF THIS SURPLUS AND THE FACT THAT OVER TWO-THIRDS OF THE BUDGET FUNCTIONS IN THE PRESIDENT'S FY 1985 BUDGET WILL EXPERIENCE A REAL DECLINE IN SPENDING, IT IS HARD TO JUSTIFY THE CONTINUATION OF OUR BLANK CHECK POLICY FOR DIRECT MEDICAL EDUCATION. CLEARLY A LIMITATION IS A PRUDENT ACTION.

ALSO, AS I INDICATED EARLIER, MEDICARE'S SUPPORT FOR MEDICAL EDUCATION ACTIVITIES WAS MEANT TO BE A TEMPORARY MEASURE UNTIL THE COMMUNITY COULD UNDERTAKE THE EXPENSE. IT IS TIME NOW FOR STATES AND LOCALITIES TO ASSUME A GREATER RESPONSIBILITY FOR THESE COSTS.

TO THIS END, WE HAVE RECENTLY ISSUED A PROPOSED RULE WHICH WOULD LIMIT MEDICARE REIMBURSEMENT FOR DIRECT MEDICAL EDUCATION COSTS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1985 BUT BEFORE JULY 1, 1986. THE LIMIT WOULD BE TIED TO MEDICARE UTILIZATION AND WOULD BE BASED ON THE LESSER OF A PROVIDER'S

ALLOWABLE COSTS DURING THAT COST REPORTING PERIOD OR DURING THE BASE YEAR. THE BASE YEAR WOULD BE THE PROVIDER'S COST REPORTING PERIOD BEGINNING DURING FY 1984.

-LIMITING COSTS ALLOWABLE FOR DIRECT MEDICAL EDUCATION TO COSTS ALLOWED IN A BASE PERIOD WILL SAVE MEDICARE $145 MILLION IN FY 1986. IF COMPARABLE LIMITATIONS WERE MAINTAINED THROUGH FY 1990, THE CUMULATIVE SAVINGS WOULD BE $2.5 BILLION. BESIDES PRODUCING BUDGET SAVINGS AND IMPROVING THE FINANCIAL STATUS OF THE HOSPITAL INSURANCE TRUST FUND, WE BELIEVE THAT THE LIMIT WILL PROVIDE AN INCENTIVE FOR THE MEDICAL EDUCATION COMMUNITY TO EXAMINE ITS PRIORITIES AND BEGIN TO RESTRUCTURE RESIDENCIES AND PROGRAMS FOR OTHER HEALTH PROFESSIONALS TO MEET THE CHANGING ENVIRONMENT OF THE HEALTH CARE MARKET PLACE.

IN UTILIZING THIS FLEXIBILITY, WE WOULD URGE THAT PROVIDERS CONSIDER DEVOTING A GREATER SHARE OF THEIR MEDICAL EDUCATION PROGRAMMING TO THE TRAINING OF PHYSICIANS SPECIALIZING IN GERIATRICS, GERIATRIC NURSES AND OTHER GERIATRIC HEALTH CARE PROFESSIONALS, IN LIEU OF SURPLUS MEDICAL SPECIALTIES.

For indirect medical education, our proposal would eliminate the doubling of the factor that had been mandated in the Social Security Amendments of 1983. This proposal would save Medicare $695 million in FY 1986 and $6.6 billion through FY 1990.

Under our proposal Medicare would still be making an additional payment for indirect medical education costs in teaching hospitals using an empirically-developed factor. It would still recognize the difference in costs between teaching and non-teaching hospitals. It would no longer, however, recognize double that difference. It is hard to justify spending $6.6 billion to double this factor without an empirical basis for doing so. Such a policy will only encourage inefficient behavior. It should also be noted that some elements of the medical education community have indicated that a reduction in the 11.59 percent adjustment is warranted.

We are also studying the issue of severity of illness within DRGs to determine whether an appropriate measure can be developed and whether such a measure should be used to adjust DRG payments to hospitals with a significant proportion of complex cases.

S. 1158

MR. CHAIRMAN, THE BILL THAT YOU HAVE COSPONSORED WITH SENATORS DOLE AND BENTSEN ACKNOWLEDGES THE NEED TO REFORM THE WAY MEDICARE PAYS FOR DIRECT MEDICAL EDUCATION. CLEARLY, WE HAVE SIMILAR OBJECTIVES IN THIS AREA AND WE ARE PLEASED TO SHARE WITH YOU THE ADMINISTRATION'S VIEWS ON S. 1158.

THE MAJORITY LEADER'S INTRODUCTORY REMARKS INDICATED THAT THE BILL WOULD ENCOURAGE A CONTINUING DISCUSSION ON MEDICAL EDUCATION AND MEDICARE. IN THE SPIRIT OF FURTHERING THAT DISCUSSION, WE OFFER THE FOLLOWING COMMENTS ON S.1158.

S.1158, LIKE THE ADMINISTRATION'S PROPOSAL, WOULD FREEZE PAYMENTS FOR DIRECT MEDICAL EDUCATION FOR HOSPITAL COST REPORTING PERIODS BEGINNING JULY 1, 1985, ALTHOUGH S.1158 USES A DIFFERENT BASE YEAR. FURTHER, BOTH PROPOSALS ADDRESS INDIRECT MEDICAL EDUCATION SPENDING AS WELL. THE TWO PROPOSALS APPROACH THE PROBLEM DIFFERENTLY.

S.1158 WOULD REDUCE PAYMENTS FOR DIRECT MEDICAL EDUCATION BY LIMITING SUPPORT TO RESIDENTS TO THE MIMIMUM NUMBER OF YEARS REQUIRED TO BECOME BOARD CERTIFIED, OR A MAXIMUM OF FIVE YEARS. THIS CONCEPT IS WORTHY OF FURTHER STUDY.

THE ADMINISTRATION'S PRESENT APPROACH IS TO LIMIT SPENDING AND LET THE MEDICAL COMMUNITY, RATHER THAN THE FEDERAL GOVERNMENT, DETERMINE HOW TO UTILIZE THE FUNDS. WE BELIEVE THAT STUDIES ON ITEMS SUCH AS GEOGRAPHICAL DISTRIBUTION OF RESIDENTS, SALARY LEVEL OF RESIDENTS, AND SUPPLY OF SPECIALTIES AND SUB-SPECIALTIES WOULD PROVIDE THE FEDERAL GOVERNMENT WITH A BETTER UNDERSTANDING OF THE GRADUATE MEDICAL EDUCATION NEEDS TO ADEQUATELY SERVE THE MEDICARE POPULATION.

S.1158 ALSO PROPOSES TO ELIMINATE SUPPORT FOR NON-CITIZEN FOREIGN MEDICAL GRADUATES (FMGS). WE SUPPORT A POLICY OF MEDICARE PAYMENT FOR MEDICAL GRADUATES WHO HAVE DEMONSTRATED AN ABILITY TO PRACTICE QUALITY MEDICINE BY PASSING THE TESTS NECESSARY TO BECOME LICENSED AND WHO HAVE EITHER ACHIEVED A PERMANENT RESIDENCY STATUS OR ARE U.S. CITIZENS. THIS APPROACH WOULD GUARANTEE HIGH-QUALITY CARE TO THE MEDICARE POPULATION IN THE FUTURE BY THESE MEDICAL RESIDENTS.

THERE ARE A NUMBER OF ADMINISTRATIVE ISSUES THAT NEED TO BE CLARIFIED AND WE WOULD BE PLEASED TO DISCUSS THESE FURTHER WITH COMMITTEE STAFF. FOR EXAMPLE:

- FURTHER EXAMINATION OF THE EFFECTS OF S. 1158 ON THE RESOURCE SAVINGS TO MEDICARE ARE NECESSARY.

- S. 1158 COULD RESULT IN A SUBSTANTIAL INCREASE IN REPORTING REQUIREMENTS. IT WOULD BE IMPORTANT TO ENSURE THAT PROVIDERS NOT BE BURDENED WITH OVERLY EXCESSIVE REPORTING, ACCOUNTING AND STAFFING REQUIREMENTS.

- HCFA WOULD HAVE TO DEVELOP AN UPDATE FACTOR FOR HOSPITALS WHOSE COST REPORTING PERIODS DO NOT BEGIN ON JULY 1, 1985. THIS WOULD REQUIRE A STUDY ON AN APPROPRIATE INDEX FOR RESIDENT SALARIES AND OTHER COSTS.

- A FIVE-YEAR LIMIT ON PAYMENT FOR RESIDENCY PRESENTS SOME DIFFICULTIES IN IMPLEMENTATION. HOWEVER, IT IS UNCLEAR WHETHER THERE EXISTS THE ABILITY TO TRACK YEARS OF RESIDENTS' TRAINING OR WHETHER IT COULD RAPIDLY BE DEVELOPED. FOR EXAMPLE, DERMATOLOGY AND OPTHALMOLOGY REQUIRE A PREREQUISITE YEAR IN INTERNAL MEDICINE. DOES THIS YEAR CONSTITUTE THE FIRST RESIDENCY? FURTHERMORE, WOULD ENTRANCE INTO A SUB-SPECIALTY AFTER QUALIFICATION IN A BASIC SPECIALTY BEGIN THE FIVE-YEAR CLOCK AGAIN? SUCH QUESTIONS DEMONSTRATE THE COMPLEX NATURE OF RESIDENCY PROGRAMS AND INDICATE THE MERIT OF FURTHER ANALYSIS.

- CLEAR AUTHORITY WOULD NEED TO BE GRANTED TO THE SECRETARY TO DEVELOP METHODOLOGIES TO DETERMINE THE PAYMENT ASSOCIATED WITH OVERHEAD COSTS RELATED TO RESIDENTS WHO ARE NO LONGER RECEIVING MEDICARE SUPPORT.

- TO ACHIEVE THE COST SAVINGS FOR THE BILL, THE RESIDENTS EXCLUDED FROM MEDICARE PAYMENT UNDER PART A OF THE PROGRAM WOULD HAVE TO BE PRECLUDED FROM BILLINGS FOR SERVICES UNDER PART B. A SPECIFIC BAR TO PART B BILLING WOULD HELP ASSURE THAT THE PROJECTED COST SAVINGS COULD BE ACHIEVED.

- SOME HOSPITALS PRESENTLY DEPEND DISPROPORTIONATELY ON FMGS. IN SOME SPECIALTIES, FOREIGN NATIONAL FMGS HOLD A SUBSTANTIAL NUMBER OF RESIDENCES. FOR EXAMPLE, 20 PERCENT OF RESIDENCIES IN PHYSICAL MEDICINE AND REHABILITATION CARE ARE HELD BY FOREIGN NATIONAL FMGS. AS STATED EARLIER, WE BELIEVE THAT REQUIRING MEDICAL GRADUATES TO BE LICENSED AND TO HAVE ACHIEVED PERMANENT RESIDENCY STATUS WOULD MOST LIKELY RESULT IN MODEST IMMEDIATE REDUCTIONS IN NON-CITIZEN FOREIGN MEDICAL SCHOOL GRADUATES. DURING THIS TRANSITION

PERIOD HOSPITALS WITH LARGE NUMBERS OF FMGs WOULD REPLACE AFFECTED FMGs WITH THE GROWING SUPPLY OF U.S. TRAINED PHYSICIANS.

CONCLUSION

I WISH TO UNDERSCORE OUR SHARED DESIRE TO TAKE POSITIVE ACTION NOW TO LIMIT THE CURRENT OPEN-ENDED FUNDING OF MEDICAL EDUCATION FROM THE MEDICARE TRUST FUNDS. BOTH THE ADMINISTRATION'S PROPOSAL AND S.1158 ADDRESS THIS PROBLEM. WE BELIEVE THAT WE CAN CRAFT A SOLUTION TO BRING ABOUT THE NEEDED REFORMS WITHOUT CAUSING GRAVE DISRUPTION IN THE MEDICAL EDUCATION COMMUNITY.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY. I WILL BE PLEASED TO ANSWER ANY OF YOUR QUESTIONS.

STATEMENT OF THOMAS D. HATCH, DIRECTOR, BUREAU OF HEALTH PROFESSIONALS, PUBLIC HEALTH SERVICE, WASHINGTON, DC

Mr. HATCH. Mr. Chairman, I propose to have my remarks entered in the record, and I will do as brief a summary as I can.

In the Public Health Service we are primarily concerned with the overall issues of education, supply, distribution, and quality of health professions.

In addition to assembling data on health professions' education, supply, distribution, practice characteristics, and future requirements, we have provided support for selected activities of national concern: particularly, with respect to the hearing today, our grants for residency training in family medicine and general internal medicine and general pediatrics, to expand and strengthen programs through providing support not available from other sources.

In addition to that, we support area health education centers around the country which focus on training in underserved geographic areas and for underserved populations.

As you know, as a result of the projected supply—and for some disciplines oversupply—of professionals, combined with serious budget constraints, the 1986 President's Budget proposes that these programs be discontinued.

In considering changes in reimbursement policy, I would make a couple of observations supplementary to those made by Dr. Desmarais.

First of all, the number of alien FMG's entering the United States has been decreasing over the recent years, while the number of U.S. citizen FMG's has been increasing. For example, the number of first-year residents who are alien FMG's dropped about 40 percent between 1982 and 1984. U.S. citizen FMG's now constitute more than 50 percent of FMG's in residency training.

In addition to that, I think it is important, as you have noted in your bill, to consider issues related to other health professionals who receive training in hospitals. About 1,600 hospitals directly operate as many as 3,600 separate training programs in nursing and the allied health professions. Many of these are supported through reimbursement direct costs of education under Medicare.

In addition, the American Hospital Association estimates that about 60 percent of hospitals are affiliated with academic institutions to provide clinical training in the full range of health professions.

While we know a good deal about the educational programs and where they are located, information on costs, financial relationships, and other factors are not well developed for these activities.

That concludes my statement, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Thomas Hatch follows:]

For Release Only Upon Delivery

STATEMENT BY

THOMAS D. HATCH

DIRECTOR, BUREAU OF HEALTH PROFESSIONS

HEALTH RESOURCES AND SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JUNE 3, 1985

Mr. Chairman and Members of the Subcommittee:

I am Thomas D. Hatch, Director of the Bureau of Health Professions of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. I am pleased to have the opportunity to appear before you to discuss various questions relating to graduate medical education and the Public Health Service's role with respect to physician supply and specialty distribution.

Mr. Chairman, this is an appropriate time to discuss the question of how best to pay the costs of graduate medical education. Over the past decade, major increases have occurred in the supply of physicians and other health professionals, in numbers and types of educational programs, and in ways of providing health care.

In my testimony, I shall describe briefly the Health Resources and Services Administration's current activities relating to graduate medical education. Of the Federal funds supporting health professions training, the programs administered by the Bureau of Health Professions represent approximately 9 percent of total funding.

FY 1986 Budget

As you know, the President's 1986 budget, as submitted in February, requests no funds for selected PHS categorical health professions education support. In view of a steadily increasing supply of physicians and nurses, rapidly growing national surpluses in these fields, and improving geographic distribution of health professionals, the categorical Federal subsidy of health professions education programs is no longer required. Extraordinarily large Federal subsidies are provided to graduate medical education through Medicare as well as through the Department of Defense and Veterans Administration medical programs.

Although no budget authority is requested for selected health professions assistance in 1986, approximately $67 million of Bureau of Health Professions funding will continue to be available for student loans from the revolving funds to approximately 3900 students at approximately 1,400 health professions and nursing schools. These repaid loan monies will enable schools to continue providing assistance to economically disadvantaged students. Significantly improved debt collection methods will help ensure and expand the amount of loan dollars available for new loans in the future.

In addition, the Health Education Assistance Loan program (HEAL) will provide $100 million of new guarantees for private loans to graduate students in health professions schools.

Current HRSA Programs Relating to GME

Mr. Chairman, under Title VII of the PHS Act, HRSA's Bureau of Health Professions currently provides aid for training of primary care physician specialists in the form of grants for family medicine training (residents, faculty, and undergraduate), grants for training in general internal medicine and general pediatrics (residents, faculty), and grants for the establishment of departments of family medicine. Of the estimated $600 million total cost of supported primary care GME programs, these grants are the source of less than 11 percent. There are strong indications that these primary care training grant programs have been successful in enhancing primary health care delivery over the last decade.

Another Bureau of Health Professions program that has made a major contribution to the training of primary care physicians is the area health education center, or AHEC, program. Emphasizing a regional approach to meeting health personnel needs in shortage areas, this program has provided funds to medical and osteopathic schools for the purpose of decentralizing education by having portions of training provided in underserved areas. Among the training programs supported have been those for primary care residency training. Many AHECs have continued to operate successfully after the start-up period of Federal support ends. The North Carolina legislature annually earmarks over $20 million to AHEC activities. South Carolina makes a similar annual commitment. The State of Kansas declined approved Federal funds in 1982 because of the availability of State support. Colorado, Illinois, and West Virginia are also receiving State support. In FY 1983, New Jersey, Massachusetts, and South Dakota reported a 50 percent non-Federal fund matching; Ohio and Maryland reported 40 percent non-Federal fund matching.

In addition to providing support for primary care physician training, the Bureau of Health Professions has pursued efforts to improve the availability and quality of information on the status of health professions personnel, including data on physician specialty supply and distribution. Working in cooperation with other Federal agencies, States, local communities, professional organizations, and other groups, we have assembled and analyzed data on current supply of practitioners and students and estimated future requirements for personnel. Our most recent report to the Congress on the status of health personnel (May 1984) describes the growth of physician training programs over the past 20 years, notes the increase in the supply of practitioners, projects surpluses in many health professions disciplines by the end of the decade, and documents progress in the development of residency training programs in the primary care physician specialties. The report also summarizes data on the extent to which practicing physicians are locating increasingly in counties that have lower physician-to-population ratios.

Trends in Foreign Medical Graduate Utilization

Mr. Chairman, with respect to foreign medical graduates, we would observe that the number of "foreign national" FMGs in U.S. residency programs has tended to decline in recent years. Between 1982 and 1984, for example, the total number of foreign national FMGs in residency training dropped 11 percent from over 6,700 to about 6,000, and the number of foreign national FMGs in *first-year* residency positions dropped 40 percent from over 2,000 to less than 1,200. Meanwhile, the number of "U.S. citizen" FMGs in residency positions has tended to increase, so that overall numbers of FMG residents — foreign national and U.S. citizen -- have reamined about level over the past several years.

As Dr. Desmarais has noted in his testimony, some hospitals depend disproportionately on FMGs to fill their residency positions. In 1983, the Council of Teaching Hospitals indicated that of their reporting membership of 424 hospitals, 102 had more than 25 percent FMG residency trainees. These "FMG hospitals" were located in 19 States and Puerto Rico. Most of the hospitals were located in heavy urban or near-urban areas -- particularly the cities of New York, Pittsburgh, Philadelphia, Detroit, and Chicago. Less is known on the distribution of hospitals with exceptionally high numbers of *foreign national* FMGs. There is no current published, verifiable information regarding the citizenship of FMG residents by hospital.

Training of Other Health Professionals

In considering changes in Medicare reimbursement it is important to remember the scope and variety of educational activities in the health professions. There are over 15,000 programs ranging from undergraduate and graduate medicine to dentistry, nursing, pharmacy and over 140 allied health occupations.

American Hospital Association data indicate that 60% of hospitals participate as clinical affiliates for academic training programs. Looking at the data in a different way, a survey conducted by the American Society of Allied Health Professions showed that 85% of collegiate programs have at least one arrangement with a hospital for clinical training and that the average number of clinical affiliations per program was 7.

A 1979 study by the Bureau of Health Professions identified some 3,300 allied health programs operated by some 1,600 hospitals. These programs had a total enrollment of 65,000 with some 35,000 graduates in such fields as clinical laboratory, radiological technology, mental health and dietetic and nutritional services.

There are some 1,400 educational programs in the country that prepare registered nurses; of this number, slightly less than 300 are hospital-based diploma programs, while the remainder are located in 2 and 4 year colleges and in universities. In addition, there are some 1,300 state approved programs to train licensed practical nurses. While less than 10% of the LPN programs are operated by hospitals, all of these programs, as well as all RN programs make substantial use of hsopitals to provide clinical education.

We are currently working with HCFA, the American Hospital Association, professional associations, and others to obtain further information on Medicare payments and other aspects of the financing of nursing and allied health programs. During the remainder of this fiscal year we will be conducting a preliminary study of recently closed educational programs and designing a study to survey the hospital's role not only in programs directly operated by hospitals but also in programs in which hospitals serve as affiliates for the provision of clinical training.

This concludes my prepared statement. I would be happy to answer any questions you may have.

Senator **Durenberger**. Dr. Desmarais, your testimony indicates that the recent regulation at HCFA was intended to be a 1-year freeze, and several of the witnesses that follow you—while I am sure they like you personally and don't doubt your word—are going to suggest that the language lays the basis for a permanent freeze. I haven't read the language, so I can't necessarily interpret it that way, but would you comment on that?

Dr. **Desmarais**. I would be happy to comment. The regulation proposes a 1-year limitation on our reimbursement for medical education, but the preamble very clearly says we are also considering the possibility of applying such a policy for a period longer than 1 year, and we specifically invite public comment on that aspect of the proposal.

Senator **Durenberger**. So, in other words, they are right. Is that right? [Laughter.]

But they are going to get a chance to tell you.

Dr. **Desmarais**. Well, I think I would only observe that the proposal itself could have proposed a longer term limitation on our payment, but we chose not to do so. But we are preserving the option of providing for something longer than 1 year.

Senator **Durenberger**. In your testimony you also indicated that you are going to have to do some studying of certain aspects of S. 1158. Obviously, when I came on this committee that was a welcome word to me, because any difficult problem we had we had a study on.

At least, once I got into the majority and felt more responsible—excuse me. [Laughter.]

The word "study" to me connotes putting things off and taking a long time to do things. Now, I know that is not true, but I get a little apprehensive when you say we have to study this part of it or that. Can you give a bit of dimension to the time that might be involved in certain of the aspects of S. 1158 that are going to take a little study? And also tell me whether or not you have already begun some analysis in the event it passes.

Dr. **Desmarais**. Well, clearly, in preparation for this hearing we have begun analysis of the proposal.

It is a little difficult for me to give you an absolute time line. I think we might be in a better position to do that after working with the committee staff.

First, we need to carefully identify whether there are going to be any likely changes in the legislation in order to, as best we can, hone in on what needs to be looked at. A study doesn't necessarily imply a formal report to Congress and many years of review, but clearly we do believe that more analysis is needed with respect to some of the aspects of the bill.

So I think later on, after this hearing is concluded, and based on all of the testimony you have received, we may all be in a better position to identify what needs to be done.

I think, clearly, that we have a commitment to work with you and to come to some understanding.

I might point out, in further answer to your earlier question, that our future plans really depend a great deal on what the Congress ends up doing, because we do know that both sides of the

Hill, are very interested in the area of reform in medical education, and our future plans will obviously take that into account.

Senator **Durenberger**. All right.

Mr. Hatch, because through no fault of your own the testimony from Government witnesses never gets here until the day of the hearing, I haven't had a chance to read your full statement; but it would be helpful if you would take just 1 minute to elaborate on what is causing the change in proportion of foreign military—excuse me; I keep saying that all the time—foreign medical grads. Six days in Central America, and all the doctors wear uniforms.

A lot of preventive health care going on down there. [Laughter.]

You indicated in your testimony that the proportion of U.S. citizens among the graduates of foreign medical colleges is rising. I would be curious to know what that reflects, and is it likely to change given the changing economics of the medical profession in the United States? If they are all looking to come back here, maybe that is going to start tailing off.

Second, some comment about the impact, if you are able to observe the impact, in areas of public health and prevention and some of the nonacute care fields, of a policy which would on its face appear to discourage education in the United States of graduates of foreign medical schools and particularly those who are not citizens of the United States. Are we going to be sending some kind of a wrong signal out to the people in other countries?

Mr. **Hatch**. With respect to the first part of your question, Mr. Chairman, I think there are several factors that have changed the mix in numbers of foreign medical graduates entering this country.

First of all, effective in 1978, I believe it was, the Immigration and Naturalization Act was modified with respect to those foreign nationals coming in on exchange visitor visas for the purpose of receiving graduate medical education. The law put significant limitations on the length of time that such exchange visitors could stay in the United States, as well as requiring that they return to their home countries for no less than 2 years after the completion of their training. I would say that up until the midseventies the larger number of foreign medical graduates were entering on exchange visitor visas, many of them staying after they had completed their training for a practice in the United States. But the new law changed that mix. Right now, I believe that less than 500 a year are coming in on exchange visitor visas.

The largest number of alien foreign medical graduates now in training in the United States are on permanent visas rather than on exchange visitor visas. That number is being reduced because of requirements that immigrant physicians pass a fairly rigorous examination before entry into the United States, as well as an English language test.

Senator **Durenberger**. I don't mean to interrupt your train of thought, but I apparently have anyway. Do some of the medical professions in the United States have the authority in some way to restrict access into the profession for graduates, foreign or noncitizen graduates? I remember reading something recently about the Florida Dental Association being sued by somebody.

Mr. **Hatch**. That is mainly controlled by the State licensing boards, where the authority lies to authorize practice.

Senator DURENBERGER. Isn't it the same thing? Do the State licensing boards have that authority?

Mr. HATCH. Yes; they do.

I think some other factors, of course, have increased the number of U.S. citizen foreign medical graduates. For example, the establishment of a series of new medical schools through the Caribbean, has significantly increased the number of U.S. citizens going over there for training, and has increased the numbers of such persons coming back for residency training.

At the same time, the number of residency slots available in the United States is approaching the point where it matches the total number of students graduating from U.S. medical schools, so that the foreign medical graduates are having increasingly difficult times being placed in residencies. So there have been a series of events over the last 5 or 6 years that have tended to slow the flow of alien foreign medical graduates to the United States.

That's where we stand today.

Senator DURENBERGER. Very good. Gentlemen, thank you very much for your testimony, and we will be working with you as we work what we hear today into a final piece of legislation.

Dr. DESMARAIS. Thank you, Mr. Chairman.

Senator DURENBERGER. Our next witnesses are a panel consisting of Dr. Donald Weston, dean of Michigan State University College of Human Medicine in East Lansing, on behalf of the American Association of Medical Colleges, accompanied by Gene L. Staples, the hospital administrator of the University of Kansas Medical Center; Dr. Neal Vanselow, vice president for health sciences at the University of Minnesota in Minneapolis, on behalf of the Association of Adademic Health Centers; Dr. Tom Ferris, who is chairman of the Department of Medicine of the University of Minnesota, on behalf of the Association of Professors of Medicine, accompanied by Dr. Jay Stein, president of the Department of Medicine at the University of Texas Health Sciences Center in San Antonio, who is also president of the Association of Professors of Medicine, and Norton Greenberger, chairman of the Department of Medicine at the University of Kansas Medical Center and president-elect of the Association of Professors of Medicine.

All right. You are Gene Staples, beginning the testimony. You are going to be followed, then, by Don Weston, and you are going to share 5 minutes, is that it?

Mr. STAPLES. Yes. We will do our best.

Senator DURENBERGER. All right, go.

STATEMENT OF EUGENE L. STAPLES, HOSPITAL ADMINISTRATOR, UNIVERSITY OF KANSAS MEDICAL CENTER, KANSAS CITY, KS

Mr. STAPLES. Mr. Chairman, last fall AAMC and other witnesses appeared before this subcommittee to describe the importance of graduate medical education and its fragile financing in a competitive era. The AAMC appreciates the continuing interest members of this subcommittee and their staffs have shown in this policy issue. This morning we have divided our testimony into two parts. Initially, I will comment on the administration's proposed May 21 regulations, and Dr. Weston, a member of the AAMC committee on financing graduate medical education, will comment on S. 1158.

As this subcommittee is aware, the administration is proposing a cap on Medicare support of clinical education. The AAMC believes the proposal will seriously threaten the clinical education of physicians, nurses, and allied health personnel. A number of points need emphasis.

First, unlike the 1-year freeze being proposed for many programs this year, the administration is proposing both a 1-year freeze and a permanent cap on medical education payments.

Second, in its proposed regulations, HCFA sets the base period for the freeze as the cost-reporting period beginning on or after October 1, 1983, but before October 1, 1984. In effect, this proposed base period would be a rollback.

Third, the administration plans to reverse, without legislation, both the long-standing Medicare tradition and the 1983 congressional directive of a cost-based passthrough which accompanied the prospective payment legislation.

Finally, the AAMC must note that changes made by Medicare are watched closely by other payers. Often Medicare sets a precedent which private payers or Medicaid programs regard as a ceiling for their policies. As a result, a permanent Medicare cap could lead to a permanent freeze by all payers.

Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough.

Therefore, the Association of American Medical Colleges is strongly opposed to the administration's proposed permanent cap on Medicare cost reimbursement of the hospitals' medical education expenses.

Before yielding to Dr. Weston, I would like to comment on the length of time required for residency training. I personally, and the AAMC organizationally, have been concerned with the ease with which specialty boards can increase training requirements. I would note that I personally made the presentation which resulted in the Accreditation Council for Graduate Medical Education, requiring an impact statement on proposed changes in residency.

The AAMC has consistently supported requiring a more open and public assessment of proposed changes. By having the Secretary review training time, you strengthen the hand of those who share my viewpoint.

Senator DURENBERGER. Dr. Weston?

STATEMENT OF DONALD WESTON, M.D., DEAN, MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE, EAST LANSING, MI, ON BEHALF OF THE AMERICAN ASSOCIATION OF MEDICAL COLLEGES, WASHINGTON, DC

Dr. WESTON. The AAMC and its members appreciate the interest of this committee on this issue, their recognition that graduate medical education has real costs, and their understanding of the interwoven relationship of residency training and patient services in teaching hospitals.

Medicine involves a number of different specialties, and each specialty area has developed its own residency training period. Because the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes support through initial board eligibility is an essential minimum training period that every patient's service payer should help finance.

Under the present Medicare statute, a resident is defined as a hospital cost when providing services in the context of an approved training program. The resident under these circumstances is not allowed to bill on a part B basis for any personal medical services provided. The AAMC assumes this arrangement would be retained for residents prior to their initial board eligibility. If residents beyond initial board eligibility or beyond 5 years cannot be included in hospital costs, the AAMC recommends amending Senate bill 1158 to allow part B bills to be rendered for physicians' services provided by individuals in residency years which may not be included in a hospital's cost.

The association recognizes that this recommendation may decrease the budget savings of S. 1158; also, it may lead to conflicts in the supervisory roles of faculty and senior residents and may lead to increasing difficulties in administering Medicare policies for paying physicians in the teaching hospital.

Because of the complexity of this issue, the association is prepared to make every effort to work with the subcommittee and its staff to be sure the conflicts raised by this issue are equitably resolved. Nevertheless, it is unfair to prohibit physicians in training, caring for patients, from being paid as doctors if Medicare is not going to support their training program.

The AAMC believes our society has the responsibility to provide necessary clinical training for physicians from U.S. schools. The association believes no similar obligation exists for graduates of nonaccredited schools or from schools outside the United States. Therefore, the AAMC recommends amending S. 1158 to eliminate Medicare support for all residents who are not graduates of accredited medical or osteopathic schools located in the United States or Canada.

It should be understood that, for some hospitals where residents provide a large portion of patient services, the immediate elimination of Medicare support for FMG's would cause substantial access and service problems for Medicare beneficiaries. The AAMC does not wish to decrease patient access to service; therefore, the AAMC recommends that S. 1158 be amended to provide a 3-year phaseout for Medicare support of residents graduating from foreign medical schools.

Thank you.

Senator Durenberger. Thank you very much.

Dr. Vanselow?

[Dr. Weston's prepared statement follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Medicare Financing of Graduate Medical Education

Presented to the
Subcommittee on Health
Finance Committee
U.S. Senate

W. Donald Weston, M.D.
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Michigan State University
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June 3, 1985

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges -- which represents all of the nation's medical schools, 79 academic societies, and over 350 major teaching hospitals participating in the Medicare program -- welcomes the opportunity to testify on Medicare's role in the financing of graduate medical education. AAMC members, working in their local communities and through national organizations, are actively involved in the development, operation, evaluation and financing of graduate medical education.

Last fall, AAMC and other witnesses appeared before this Subcommittee to describe the importance of graduate medical education and its fragile financing in a competitive era. The AAMC appreciates the continuing interest members of this Subcommittee and their staffs have shown in this policy issue. In an era of deficit reduction proposals, the AAMC especially appreciates the willingness of this Subcommittee to balance the public policy issue of financing clinical education with the policy issue of deficit reduction.

The Association's testimony is divided into two sections: (1) comments on the Administration's proposed regulations which would impose a one year freeze and a permanent cap on Medicare's support of graduate medical education and (2) observations and questions about S-1158 which was introduced on May 16 by Senators Dole, Durenberger, and Bentsen. In addition, the Association wishes to include with its testimony the enclosed "Statement of Issues" published by the AAMC Committee on Financing Graduate Medical Education in March of this year. While that committee has not yet arrived at a recommended AAMC policy on GME financing, their statement sets forth a number of major concerns in this area.

The Administration's Proposal

Once again this year, the Reagan Administration is using the Federal budget process to propose major changes in the Medicare system for paying hospitals. Three of their proposals are of significant concern to teaching hospitals:

- o the proposed one-year freeze in the hospital-specific, regional, and national prices used to determine DRG payments;
- o the proposed 50% reduction in the so-called indirect medical education adjustment; and
- o the proposed permanent cap on payments for direct medical education costs.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals; collectively, the resulting decrease in revenues from the three proposals would cause serious financial problems for teaching hospitals. Because of the subject of the hearing, the AAMC will limit its testimony to the Administration's proposal to freeze and place a permanent cap on direct medical education payments. Proposed regulations to implement this policy were published in the May 21 Federal Register.

The AAMC believes the Administration's proposal for a permanent cap will seriously threaten the clinical education of physicians, nurses, and allied health personnel. A number of points need emphasis. First, unlike the one-year freeze being proposed for many programs this year, the Administration is proposing both a one year freeze and a permanent cap on medical education payments. The permanence of their proposal is most clearly stated in the preamble for the proposed regulation:

> ". . . it is our intent to maintain limits on Medicare payments for the direct costs of graduate medical education for subsequent years, fiscally equivalent to the limits that would result from a renewal of these regulations, as proposed" (emphasis added), p. 21027.

As a result of this proposed policy, Medicare would provide decreasing real dollar support for clinical education regardless of the hospital's efficiency in operating the program, the number and types of students trained, or the national need for individuals trained in a particular field.

Secondly, in its proposed regulations, HCFA sets the base period for the freeze as the cost reporting period beginning "on or after October 1, 1983 but before October 1, 1984." In effect, this proposed base period would ignore cost increases already incurred in the present year. The proposed policy would roll the freeze back to a prior fiscal period. Thus, the payment policy would actually be a roll back with a permanent cap.

Third, the AAMC notes that the Administration is not requesting legislation to implement this major change. The Administration plans to reverse without legislation both the long-standing Medicare tradition and the 1983 Congressional directive of a cost based passthrough which accompanied the prospective payment legislation. HCFA is taking this approach despite several recent Congressional hearings on this matter and despite the fact that three specific bills have been introduced in the Congress, including S. 1158. The AAMC believes it is inappropriate for HCFA to ignore this Congressional interest.

Finally, the AAMC must note that changes made by Medicare are watched closely by other payers. Often, Medicare sets a precedent which private payers or Medicaid programs regard as a ceiling for their policies. As a result, a permanent Medicare cap could lead to a permanent freeze by all payers. This would destroy the teaching hospital's ability to support clinical training for the next generation of health professionals, and thus to serve the health care needs of the nation.

Reducing Medicare support by permanently capping the direct medical education passthrough as the Administration recommends will weaken graduate medical, nursing, and allied health education programs. Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough. Therefore,

> the Association of American Medical Colleges is strongly opposed to the Administration's proposed permanent cap on the Medicare cost reimbursement of a hospital's medical education expenses.

The Dole-Durenberger-Bentsen Proposal

On May 16, 1985 Senators Dole, Durenberger and Bentsen introduced S. 1158, a proposal for changing the conditions under which the financing of graduate medical education would continue under the Medicare program. The AAMC and its members appreciate the Senators' interest in this issue, their recognition that graduate medical education has real costs, and their understanding of the interwoven relationship of residency training and patient services in teaching hospitals. While the AAMC governing board has not yet taken a formal position on S. 1158, the proposal has been discussed with the Association's Committee on GME Financing and its Executive Committee. Moreover, several of the elements in the proposal have been discussed also at the spring meetings of the Association's Councils of Deans, Academic Societies, and Teaching Hospitals.

Section (P)(i): One Year Freeze

The AAMC is fully aware of the Federal budget deficit and its impacts on our economy. At the same time, it should be noted that teaching hospitals have experienced major Medicare payment reductions in the past few years. Hospitals have responded by holding down costs and cutting expenses, including personnel. Nevertheless, hospitals still face the inflation present in our general economy including inflation in the cost of operating clinical training programs. Any freeze weakens the hospital's financial stability. Therefore, the AAMC recommends

> that S. 1158 be amended to provide that the Medicare passthrough for medical education costs be increased by the same percentage used to increase the Federal component of the DRG prices.

Section (P)(ii): Initial Board Eligibility

Education for the contemporary practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Because medicine involves a number of different specialties, each specialty area has developed its own residency training period. The AAMC believes each of those training programs is essential and in the national interest; however, in the present fiscal situation, the AAMC understands program policies and fiscal policies must be balanced. The AAMC believes that any limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. S. 1158 would limit funding in each specialty field to the minimum number of years required for initial board eligibility. Because the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes

> support through initial board eligibility is an essential minimum training period that every patient service payer should help finance.

It should be understood that this approach does not provide full support for the subspecialty fields of internal medicine, some surgical subspecialties, and a few other subspecialties. In his statement accompanying the introduction of S. 1158, Senator Bentsen observed

> . . . I am not yet satisfied that the question of funding graduate fellowships has been properly addressed, particularly as it relates to internal medicine residencies." (Congressional Record, S6344).

The AAMC shares the Senator's concerns. The AAMC does not want to leave the impression that these programs are either unnecessary or conducted without training costs. Therefore, the AAMC requests that any legislation limiting Medicare's financing role to initial board eligibility include in its accompanying Committee report a clear statement that it is an appropriate function for other Federal agencies and programs -- such as the Public Health Service, the Veterans Administration, and the Department of Defense, as well as other public and private sources -- to support subspecialty training beyond primary board eligibility. Moreover, the AAMC suggests that Section (P)(i)(II) be modified to require the Secretary to examine fellowship training in addition to the number of years of training required for initial board certification.

Under the present Medicare statute, a resident is defined as a hospital cost when providing services in the context of an approved training program. The resident under these circumstances is not allowed to bill on a Part B basis for any personal medical services provided. The AAMC assumes this arrangement will be retained for residents prior to their initial board eligibility. For residents beyond initial board eligibility who are not eligible for Part A Medicare funding under the proposal, S. 1158 raises a number of difficult policy questions. For example, under present law, residents in thoracic surgery and cardiology programs may not bill Medicare patients for services on a Part B basis because the residents are included in the hospital's costs. Under S. 1158, these residents-in-training may not be included in a hospital's costs. It does not seem reasonable to preclude these trainees from being paid on both a Part A and a Part B basis. If Part A payment is to be limited to the initial eligibility required to produce a competent practitioner, advanced residents should be thought of as physicians in the early years of their practice. The services provided by advanced residents should be supported from the physician component of Medicare. Consequently, if residents beyond initial board eligibility or beyond five years cannot be included in hospital costs, the AAMC recommends

> amending S. 1158 to allow Part B bills to be rendered for physician services provided by individuals in residency years which may not be included in a hospital's costs.

The Association recognizes that this recommendation may decrease the budget savings of S. 1158, may lead to conflicts in the supervisory roles of faculty and senior residents, and may lead to increasing difficulties in administering Medicare policies for paying physicians in a teaching hospital. The Association is prepared to make every effort to work with the Subcommittee and its staff to be sure the conflicts raised by this issue are equitably resolved. Nevertheless, it is unfair to prohibit physicians-in-training caring for patients from being paid as doctors if Medicare is not going to support their training programs.

Section (P)(ii)(II): Limit to Present Training Requirements

In the past few years, a number of residency programs have increased the required number of years of training to achieve board eligibility. The AAMC has been concerned that some recent and pending proposals have not considered adequately the economic impacts of extending the training. The Association has attempted to stimulate private sector efforts to balance educational and economic concerns. For example, at the request of the AAMC, the Accreditation Council for Graduate Medical Education (ACGME) considered the issue of changes in specialty board certification requirements that affect the special requirements for the accreditation of programs in graduate medical education. The following statement was approved and has been transmitted to the American Board of Medical Specialties and to the specialty certifying boards.

> "The ACGME recognizes that a mechanism is in place for review of a Statement of Justification/Impact Statement which must accompany requests for approval of revisions of 'Speciial Requirements.' The ACGME recommends that requests for changes in the duration of training programs not be approved, unless there has been full and open discussion of the broad impact of those changes upon the specialty itself, upon allied disciplines, upon the educational institutions providing the training and upon the public interests. This may include convening an appropriate forum for discussion of specific cases. The ACGME recommends that specialty certification bodies contemplating alteration of the duration of residency training requirements for certification should initiate discussion of the proposal with the Residency Review Committees of which they are sponsors early in the process."

Specialty certifying boards are autonomous entities that establish the criteria and standards individual physicians must meet to be certified as specialists in each of 24 specialties. Changes in educational requirements for certification may be made by each board without further ratification by any other agency. The American Board of Medical Specialties (ABMS) must be informed of planned changes 180 days in advance of their effective date, but the ABMS has no power to approve or disapprove changes in educational requirements of its member boards.

It is apparent that the boards have total control over the education that their candidates must complete to be eligible for certification. They establish the length of their training programs and have a strong influence on the content by the nature of their examinations. A board can change its educational requirements unilaterally without consideration of the impact of the change on the programs of other boards or the teaching hospitals.

In April of 1984, the AAMC submitted a formal request for an amendment of the ABMS bylaws to require member boards to submit changes in their educational requirements that had economic or programmatic impact (such as lengthening of training, procedural requirements, etc.) to the ABMS for approval. While our efforts in this regard have not been completely successful, we believe we have significantly raised the consciousness of those directly involved in these decisions.

The Association is pleased that the sponsors of S. 1158 recognize that the length of residency training is not static and that they have provided for a policy review of this subject after three years. While the bill provides that the Secretary shall consult with the Accreditation Council on Graduate Medical Education (ACGME) prior to making a decision the AAMC is concerned with adding this function to an accreditation agency. Instead of consulting with ACGME, the AAMC recommends the Secretary consult directly with the five organizations which sponsor the ACGME.

The Association would request, however, a clarification in paragraph (P)(ii)(II). To ensure that the Secretary does not use changes in the training period of one specialty to impose length of training requirements on another specialty, the AAMC suggests the following revision: ". . . or, after January 1, 1989, in the event that the required number of years in training for a given specialty increases, the number of years specified by the Secretary for that specialty" (additions underlined).

New Programs

As the hospital field restructures and realigns, hospitals are making changes in their training programs. Some hospitals are increasing residency programs; others are shrinking them. In the second and later years of the proposal, the AAMC understands hospitals increasing the number of initial board trainees could include the additional residents in their costs while hospitals decreasing programs would receive reduced payments. This is an important and realistic feature of the proposal, which the Association supports.

Section (P)(iii): Foreign Medical Graduates

Unites States medical and osteopathic schools are presently graduating over 16,000 physicians annually. Each of these schools has been peer-reviewed and is fully accredited. All recent physician manpower studies show U.S. medical and osteopathic schools are training an adequate number of physicians for our nation.

In addition to the U.S. graduates, a large number of foreign-trained physicians are entering the Unites States. Many of these foreign trained physicians enter residency training programs where they are supported by patient service revenues, including Medicare payments. In his statement accompanying the introduction of S. 1158, Senator Durenberger congratulated U.S. medical schools on decreasing the number of students admitted. To the AAMC, it does not seem reasonable to encourage accredited U.S. schools to decrease their enrollment while permitting the growing number of U.S. citizens training in foreign, even unaccredited, medical schools to qualify for Medicare reimbursement.

The AAMC believes our society has a responsibility to provide necessary clinical training for physicians from U.S. schools. The Association believes no similar obligation exist for graduates of non-accredited schools or for schools from outside the United States. Therefore, the AAMC recommends

> amending Section (P)(iii) to eliminate Medicare support for all residents who are not graduates of accredited medical (or osteopathic) schools located in the U.S. or Canada.

The Association recognizes that our nation may wish to continue training a limited number of foreign graduates for purposes of economic development, foreign relations, cultural exchange, and foreign aid. The AAMC supports public funding for foreign physicians in programs designed to train and return them to their own society, however, the AAMC believes special purpose funds should be used for these training purposes.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for FGMs would cause substantial access and service problems for Medicare beneficiaries. The AAMC does not wish to decrease patient access to service. Therefore, the AAMC recommends

> that S. 1158 be amended to provide a three year phase-out for Medicare support of residents graduating from foreign medical schools.

A three year transition should allow the hospital and its medical staff to modify programs, personnel, and services while maintaining patient access to care.

Section (c)(1): GAO Study

In requiring a study comparing the costs of care in teaching and non-teaching hospitals, the AAMC is pleased to note that S. 1158 requires the study to include both hospital (part A) and physician (part B) expenditures in the two settings. At least two studies comparing teaching hospital costs have found that while patient care costs are higher in teaching hospitals, the difference in total admission cost is diminished by including lower total physician charges in teaching hospitals. This is especially true for surgical cases where Medicare does not allow an assistant at surgery fee in a hospital sponsoring a surgery training program.

The AAMC does have one reservation about the proposed GAO study. It is possible that the higher costs incurred by the ancillary-intensive teaching hospital admission are offset, at least partially, by the use of fewer medical services during the illness (e.g., fewer re-admission or fewer ambulatory care services) or by fewer days of restricted activity for the patient. No study has examined the costs of teaching and non-teaching hospitals in light of the patient's total illness costs; such a study is needed.

Indirect Medical Education Adjustment

S. 1158 does not directly address the resident-to-bed adjustment in DRG payments presently provided to teaching hospitals. However, this adjustment is frequently misunderstood because of its "medical education" label. In the Secretary's report on Hospital Prospective Payment for Medicare, DHHS proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. As Congressional committees considered the proposed Medicare prospective payment system early in 1983, the Congressional Budget Office (CBO) prepared estimates of the impact of the new payment system including the resident-to-bed adjustment on different types of hospitals. Hospitals were compared on the basis of region, urban/rural location, bed size, ownership and teaching status. CBO estimates showed that teaching hospitals would suffer disproportionate revenue losses under the proposal and that the amount of the loss would be relatively greater for hospitals with at least .25 residents per bed than for hospitals with lower resident-to-bed ratios. Because the Department's proposed adjustment did not provide equitable treatment for tertiary care/teaching hospitals, Congressional committees asked CBO staff to estimate prospective payment impacts using a doubling of the Department's proposed adjustment. The resulting estimates showed teaching hospitals would be benefitted or penalized under the new system in approximately the same proportion as non-teaching hospitals. Thus, a doubling of the proposed resident-to-bed adjustment provided the desired equity between teaching and non-teaching hospitals.

This Subcommittee clearly recognized the mulitple deficiencies the adjustment could help correct.

> This adjustment is provided in the light of doubts...About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

In the AAMC's judgment, the resident-to-bed ratio serves as a proxy to adjust for inadequacies in prospective payment, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals;

- no recognition for the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- decreased productivity which results from including trainees in the hospital programs; and
- additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is, in fact, a proxy measure to provide apropriate compensation for the added patient service costs.

The AAMC is concerned that the limitation of Medicare support to initial board eligibility for direct medical education costs could be carried over to the residents included in the resident-to-bed adjustment. In the Association's view, this would be inappropriate. All residents, regardless of years of training, have been counted in determining the correct size of this proxy referred to as the resident-to-bed adjustment. Therefore, all residents, regardless of years of training, should be used in making adjustment payments to hospitals. It is important that the data used for the adjustment analysis and the adjustment payment be the same.

association of american
medical colleges

AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

Statement of Issues

March, 1985

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In the last five years, the AAMC has completed comprehensive reviews of both graduate and undergraduate medical education.* Among the common themes of these reports is the conclusion that a contemporary medical education requires completion of both medical school and residency training in order to be prepared for independent medical practice. Medical schools provide the general professional education which is the foundation of all medical practice. Residency training or graduate medical education provides the formal clinical education that develops the skills and experience necessary for independent practice. Residency programs are accredited by the Residency Review Committees under the supervision of the Accreditation Council for Graduate Medical Education.

Graduate medical education is not focused on the university campus. It takes place primarily in teaching hospitals. Residents, working under supervision, learn clinical medicine by hands-on participation in the care of hospital patients. Patients are being treated and residents are being trained through the same activities. In effect, both products -- patient care and education -- are being simultaneously, or jointly, produced in the teaching hospital.

The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs -- education is not simply a by-product. Adding the educational role involves additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. These costs are real. If graduate medical education is to continue, these costs cannot be avoided. Therefore, the growing debate about financing graduate medical education should not be one about paying or not paying these costs. Rather, the debate should be about the most appropriate method of paying for the costs of residency training.

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*Graduate Medical Education: Proposals for the Eighties (1981) and Physicians for the Twenty-First Century (1984).

For the past several decades, the teaching hospital's added costs for residency training have been financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984 survey of stipends paid to housestaff show 81% of the stipends and benefits are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes patient service revenue has been and continues to be the primary source for supporting the total costs of graduate medical education.

The AAMC has had a long-standing policy on financing graduate medical education which was reaffirmed in 1980 when the AAMC published the report of its Task Force on Graduate Medical Education. This three-year task force recommended that:

> Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospital (p. 94, emphasis added).

The recommendation was consistent with private payer practices and with Congressional intent for the Medicare program. Many Blue Cross agreements throughout the country explictly provide for payment of these costs. Congress clearly established payments for residents in training as a legitimate Part A Medicare expense in the original Medicare statute.

The AAMC continues to believe patient charges and reimbursements are an appropriate method of financing graduate medical education. In fact, if all, or most, of the nation's hospitals participated in graduate medical education, patient service financing of residency training could survive in the face of the increasingly competitive hospital marketplace. However, only 2 percent (125) of the nation's 5,900 community general hospitals provide 50 percent of the nation's residency training. Another 1,100 hospitals provide the remaining half of residency training. These 1,225 hospitals bear the cost of training the nation's entire supply of residents. The remaining 4,600 community hospitals -- as well as health maintenance organizations, competitive medical plans, and preferred provider organizations -- obtain the benefits of fully trained physicians without sharing in the cost of the training itself. This gives the non-teaching hospital an advantage in setting its charges and negotiating contracts. In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded.

The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and explore future alternatives for financing residency training. The Committee is chaired by J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and the members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the Committee were held in November, January and February and alternatives for financing graduate medical education were explored. This paper has been prepared to summarize the discussions of the Committee and to explain the competing views on the issues of financing graduate medical education reviewed by the Committee.

The Committee's discussions have focused on five topics:

- the need for special funding for graduate medical education in the patient care payment environment that is evolving;
- the advisability of creating a societal funding mechanism for graduate medical education rather than having each payer establish its own policies;
- the number of training years to be financed with any separate funding and the resulting manpower controls that accompany various alternatives;
- the increasing use of non-hospital sites, especially ambulatory care settings, for residency training; and
- the responsibility for training physicians educated in foreign medical schools.

The remainder of this report explores each of these topics in some detail in order to provide AAMC members, physicians and hospitals, third party payers, and public policy analysts with an understanding of the conflicting viewpoints within the medical education community.

The Need for Separate Funding

Patient care financing of graduate medical education has well served teaching hospitals, physicians-in-training, and society for several decades. Hospitals have been able to expand positions available to meet the increasing number of medical school graduates, specialties have upgraded their basic clinical training requirements, new subspecialties in medicine and surgery have developed, and new technologies have been widely disseminated.

Some Committee members and some AAMC members believe that teaching hospitals may be able to compete in the new environment without separate funding for the higher costs that result from graduate medical education. Until evidence to the contrary is clear, they believe that it would be unwise for the AAMC to advocate alternate financing arrangements which may jeopardize some of the benefits of the current system. These benefits include the freedom of medical students to elect to train in the specialty of their choice and the ability of teaching hospitals to offer a variety of residency programs.

The competing view, held by the majority of the Committee and many AAMC members, is that patient revenues in the future price-competitive market may be insufficient to support financing of graduate medical education and that alternatives must be found or at least explored. This group believes payers will withdraw their explicit support and/or cut back on their implicit support for graduate medical education. As a result, teaching hospitals will be forced either to limit other hospital programs and services to support the educational mission or to reduce the numbers of residents and faculty they support. Other missions also may increasingly draw on the resources of the teaching hospitals. For example, many teaching hospitals are being asked to provide increasing amounts of care to the indigent without concommitant increases in state or local support. Thus, institutional resources are being stretched substantially and may be unable to support educational programs at current levels.

In substantial part, this dichotomy of viewpoints reflects different member experiences and points of reference. Those who advocate continuing to finance graduate medical education with patient service revenues present their viewpoint with reference to a payment system based on negotiated prices. They believe the teaching hospital has a marketable resource in its educational activities. They see education providing a quality-enhancing benefit not available from non-teaching hospitals. Moreover, in a negotiated market, a hospital is free to reject a price which does not enable it to meet its patient care and educational costs.

Those who advocate establishing separate financing for graduate medical education present their view with reference to a payment system based either on administered prices set by an external entity or on a payment system dominated simply by lowest price. For example, Medicare's basic prospective payment formulas are designed to pay a fixed price for a given patient irrespective of whether the hospital does or does not offer residency training. Unless separate funding is added, such as Medicare's current medical education passthrough, the teaching hospital must provide two products (i.e., patient care and education) for the same price the non-teaching hospital must provide only patient care. For non-Medicare payers, if price is the only selection criteria, there will not be additional funding for graduate medical education.

Given these differing reference points and perspectives, the AAMC faces two fundamental but conflicting assumptions:

> public and private payers will recognize the unique contributions and benefits of teaching hospitals and be willing to pay teaching hospitals higher payments. As a result, the AAMC need not explore alternative arrangements for financing graduate medical education;

or

public and private payers of hospital services are becoming increasingly resistant to including adequate funding for the support of graduate medical education in their general patient care payments. As a result, the AAMC must explore options to provide support for this essential mission of teaching hospitals.

Resolution of this fundamental difference in working assumptions must precede discussions about the methodologies and structures for financing graduate medical education.

The Committee premised its development of alternative financing arrangements on the latter assumption cited above. This does not imply that it is inappropriate to finance GME with the general operating revenues of teaching hospitals. It does recognize, however, that in the future new payment systems for patient services may not provide teaching hospitals with sufficient funds to finance both their patient care and educational missions. Therefore, the Committee has explored alternatives and identified conflicting issues that must be resolved.

Scope of Proposals

Health care financing arrangements, both public and private, are undergoing substantial changes:

- o payers are increasingly interested in paying only for the immediate services used by their beneficiaries,
- o predetermined payments are replacing retrospective cost reimbursement, and
- o low price is replacing access as a criteria for selecting hospitals.

In this environment, each payer has an economic advantage in behaving as a marginal price purchaser paying only the incremental costs arising from services provided to its patients. This behavioral incentive, however, is in conflict with the broader societal interest in maintaining and supporting commonweal services benefiting all collectively but no payer individually.

Adequate financing for graduate medical education requires each payer to subordinate some of its economic self-interest to the broader social interest of adequately training new physicians. This subordination of self interest can be achieved in two ways: (1) society can impose a tax to support the costs of residency training or (2) payers can individually be persuaded for social, ethical, or public image reasons to share in financing residency training.

The Committee recognizes advantages and disadvantages to each approach. The taxation approach is the most likely to provide comprehensive financing and to avoid conflicting health manpower policies across payers. However, requiring a Federal tax, administered by Federal officials, seems to be contradictory to the present political climate. Morover, it would make residency training dependent on a single source of funds and subject it to annual debates in the Federal budget. Such fiscal control could lead to massive intervention in medical education. Similar reservations exist for state-administered taxes. In addition, a state tax approach could lead to conflicting manpower policies across the nation.

The individual payer approach does not require major Federal legislation or a new bureaucracy and it permits manpower training decisions to remain at the institutional level. It is not clear, however, whether payers will subordinate their economic self interest. Some may; others may not. As a result, the revenue base for residency training may be incomplete and constantly changing.

The preferred course is unclear. Should the AAMC seek a comprehensive, national tax or should the AAMC concentrate on national payers (e.g., Medicare) while individual members work with their state and with individual payers? Each choice has major risks.

The Training Period To Be Funded

If separate funding is provided to support graduate medical education, the amount of that funding could be set by determining the number of residents to be financed and the number of training years to be supported. Three options on the length of training which would be supported by separate funding are available: (1) fund residents for a fixed number of years (e.g., 3, 4, or 5) regardless of the specialty in which the resident is training; (2) fund residents only for the period of time necessary to obtain initial board eligibility; or (3) fund residents in all accredited programs for initial and subspecialty training.

Option one provides separate funding for a fixed number of years per resident. Residents in programs which can be completed in the fixed number of years are supported throughout their training. Residents in the longer programs would receive funding for the fixed number of years but they, the hospital and the staff physicians would have to support the remaining years with patient service revenues, grants, appropriations, contracts, or philanthropy. For example, if the separate funding were provided for the first three years of residency training, residents in three year programs would be supported for all training years. Residents in programs lasting four or more years would receive separate funding only for the first three years of their program. Thus, under the three year example, residents in family practice, pediatrics, and internal medicine would receive funding throughout their basic training. Residents in all other specialties and subspecialties would receive funding only for the first three years of their program. Advocates of fixed year funding emphasize two advantages to the approach. First, it minimizes external regulation. It does not require an external entity to allocate residency positions by specialty or across hospitals because payment is made based solely on the number of residents at or below the fixed years of training. Secondly, the advocates generally believe it will increase the proportion of residents training in the primary care specialties and decrease the proportion of residents undertaking subspecialty training. Detractors are concerned that the fixed year funding creates instability and uncertainty for residency programs lasting beyond the fixed year threshold. They note that strong training programs are built across time and need stability of financing and personnel. Detractors are also concerned that funding less than the years required for certification may lead to: inappropriate efforts to shorten training time, residents who drop out of training programs before completing them, or fee-for-service billing for residents who have not completed their training programs.

A second alternative varies the number of years of separate funding with the number of years of specialty training required for initial board certification. Residents in internal medicine would be supported for the three years of internal medicine with no separate funding provided for subspecialty training. Residents in surgery would be supported for the five years required for general surgery with no additional separate funding provided for the extra years required for thoracic, plastic, or colon and rectal surgery. The principal advantage of this alternative is its explicit recognition of the variation in the time required for initial board certification in different specialties. Some Committee members are concerned that separate funding which varies with the training required for initial board eligibility may lead to the development of a manpower planning entity which designates the number of approved positions in each specialty. The majority of the Committee believes, however, that a manpower planning entity is not necessary if separate funding is limited to the initial training program.

The majority also believes their position would be strengthened if the number of years of support for each specialty is limited to the present requirement. The major disadvantage of this alternative is its limitation to initial board eligibility. In many specialties -- including internal medicine, pediatrics, and surgery -- some residents undertake subspecialty training after they have completed, or could have completed, the initial residency. This alternative would not provide separate funding for residents in subspecialty training. Other sources of financing would be needed to support subspecialty programs.

The third alternative provides separate funding for all residents training in approved training programs. This approach provides separate funding for full specialty and subspecialty training in all disciplines. Advocates of this approach emphasize that it provides full funding for the period of time that the physician-in-training is subject to the direction and supervision of faculty. It does not provide an economic disincentive to developing or pursuing the longer training programs. Detractors note the open-endedness of this approach. They believe the funding entity is likely to limit its financial exposure under this option by developing explicit manpower training policies. The detractors are concerned that some entity may determine how many positions in each type of training will be offered and which hospitals will be approved for funding.

The three funding options are dramatically different. They vary in terms of ease of administration, financial comprehensiveness, and likely manpower regulation. Each approach has supporters. Selection of any one approach will bring fundamental change to residency training.

Non-Hospital Training Sites

Increasingly, acute care hospitals are being used only for the most intensive portion of a patient's illness or procedure. This has changed both the kinds of cases admitted to inpatient units and shortened the length of time the patient is in the hospital. As a result, several specialties are are now trying to incorporate non-hospital experiences in their residency programs. This creates problems because hospital patient care revenue has been the predominate source of support for residency training. While hospital charges and costs presently include expenses for graduate medical education programs, ambulatory care providers do not have such costs in their present charges. Increasing charges in ambulatory or long-term care settings to support residency training would disadvantage some providers as price competition in all areas of medical care increases. Innovative financing approaches must be developed and evaluated for both long-term care and ambulatory settings.

Residency Positions To Be Supported

The United States has 127 medical schools accredited by the Liaison Committee on Medical Education (LCME) and 15 accredited osteopathic schools from which there are a total of approximately 16,200 graduates. The AAMC Committee believes that the United States has an obligation to provide the resources necessary to train these graduates. The Committee believes society has no similar obligation to provide and financially underwrite graduate medical education for graduates of non-accredited medical schools or schools outside the U.S. At the present time 18% of residency training positions are occupied by physicians graduating from foreign medical schools. While some U.S. hospitals may wish to continue training foreign graduates, the Committee believes such training need not be supported by funding arrangements designed to support graduate medical education. Because almost twenty percent of current residents are foreign medical graduates, adoption by payers of the Committee's position would substantially reduce the funding needed for graduate medical education.

Conclusion

This statement of issues is focused on five major topics surrounding the future financing of graduate medical education. The Committee recognizes that numerous secondary issues have not been addressed. For example, approaches which increase the uncertainty of residency support may discourage economically-disadvantaged individuals from choosing a medical career. Eliminating funding for foreign medical graduates may pose special transition problems for patient services in some hospitals. The Committee is aware of these and other secondary concerns but chose to omit them in order to address the primary topics in a more tightly focused way.

During the last two decades, hospitals have operated for the most part in a cost reimbursement era with substantial autonomy. They have competed with each other on the basis of quality and scope of services; there was minimal competition on the basis of price. The Committee recognizes that the environment of the mid-80's and beyond is different and that hospitals must improve the efficiency of all their services. Price per unit of service is becoming the basis of competition. Even efficient teaching hospitals are disadvantaged in the price competitive market for a variety of reasons including:

- the provision of a disproportionately large share of care to the indigent;
- the treatment of the most severely ill patients;

- the provision of regional stand-by services, such as burn centers, pediatric and adult open-heart surgery centers, and transplant centers;
- the presence of clinical research efforts to advance diagnostic and treatment capabilities; and
- the provision of graduate medical education to maintain the supply of physicians for this country.

All of these functions are important to the missions of teaching hospitals, and all make teaching hospitals more expensive to operate than non-teaching hospitals. The Committee's task is to examine only changes in the financing of graduate medical education, but it clearly recognizes that even if separate funding for graduate medical education is adopted, teaching hospitals will continue to require special consideration in any hospital financing scheme for the other functions that distinguish them from non-teaching hospitals. While financial support for graduate medical education will not eliminate the teaching hospital's problems, support for GME will contribute to a more equitable market in which teaching hospitals are less disadvantaged.

STATEMENT OF NEAL A. VANSELOW, M.D., VICE PRESIDENT FOR HEALTH SCIENCES, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN, ON BEHALF OF THE ASSOCIATION OF ACADEMIC HEALTH CENTERS, WASHINGTON, DC

Dr. **Vanselow**. Senator Durenberger, as you know, I am vice president for health sciences at the University of Minnesota, but I am also a member of the board of directors of the Association of Academic Health Centers. I am speaking today to outline the board's position on the funding of graduate medical education.

I believe you know that our association is comprised of about 100 academic health centers in the United States and Canada. The chief administrative officers of these centers are responsible for the various education programs in the health professions and for the principal teaching hospitals.

Our association has not testified regularly at hearings such as this. We have decided to make an exception on this issue because we recognize its tremendous importance. And I think we also recognize the incredible dilemma that all of us face. On the one hand, there is the need to balance the Federal budget, and we want to be responsive to this; on the other hand, our system of health care is undergoing a very rapid dramatic change. We don't want to do irreparable harm to the ability of our hospitals and our universities to respond to these changes. Above all, we want to maintain the tradition of educational excellence which we believe has been a very important factor, giving our country the best system of health care in the world.

In an attempt to deal with this dilemma, our board has developed six principles which we hope will be used by Congress in formulating new legislation on the subject of graduate medical education. We offer these principles not because we necessarily think they will produce a better system than we now have but because we feel that they will reduce costs while at the same time preserving the essential elements of the system.

I will go over these principles very briefly, because they have already been outlined in some detail in our written statement.

First of all, we believe that considerable money could be saved by discontinuing Medicare payments for residency positions filled by graduates of foreign medical schools; I am referring to both alien FMG's and foreign medical school graduates who are U.S. citizens. We view this as both a manpower and a quality issue. We believe that accredited medical and osteopathic schools in the United States and Canada have the capacity to meet our Nation's medical manpower needs, but that they also produce graduates who are of much better quality than those produced by most foreign schools.

Our second principle? We believe that additional money could be saved by limiting Medicare support for residents to the number of years now required for initial board certification. We believe these payments should be made as they now are, through Medicare-reimbursement to hospitals, and we would also urge that hospitals be given maximum flexibility in the use of the funds that they receive so that they can place more emphasis on innovative Training Programs, such as residents spending more time in ambulatory care settings.

Third, we recommend that the portion of a resident's stipend which is eligible for Medicare reimbursement be the same for all specialties in all hospitals, with adjustments for area cost of living, with periodic adjustments for inflation and with minor adjustments for seniority.

Fourth, we would urge that Congress continue to reimburse hospitals' costs associated with clinical training of nurses and allied health professionals. The amount involved here is relatively small, but continued support is vital to our ability to educate these students.

Fifth, we believe the so-called indirect cost proxies should be left in place until the nature and the extent of the products that reimburse this work can be further clarified and alternate reimbursement mechanisms can be designed.

Finally, we hope that Congress will not cast into legislation rigid requirements regarding the numbers and types of health professionals we train, quotas for specialties, curriculum requirements, and so on. We believe that these questions are best left to the marketplace. And I would like to emphasize that, Mr. Chairman. We think marketplace factors are very important here.

I might just make a few comments on this bill, S. 1158. It appears to be consistent with the principles I have outlined on the treatment of alien foreign medical graduates, the length of residency training supported by Medicare, continued support for the clinical training of nurses and allied health professionals, and the handling of the indirect cost proxies.

We also believe it would permit the marketplace factors to play a very important role in determining the future size and nature of residency programs.

The bill is not consistent with the principles I have outlined, or is silent, on uniform resident stipends and the discontinuation of Medicare payment for residency positions occupied by U.S. citican FMG's.

Finally, I would like to be anecdotal, to give you one example, Mr. Chairman, of how this would impact on my own hospital, the University of Minnesota Hospital. I do this simply to make the point that we are trying to be responsive to the need to balance the Federal budget, but we are going to feel some pain in the process.

We have about 300 house officers assigned at any time to the University of Minnesota Hospital. About 20 percent of these are beyond their primary board certification, and under the proposal I have just made we would lose Medicare reimbursement for them. And yet, the principles that I have outlined have a great deal of support among our faculty, because we see them as the best way out of a rather tough dilemma, and we feel they will not make it impossible for us to maintain Training Programs of high quality.

I would be happy to respond to any questions that you might have.

Senator **Durenberger**. All right. Thank you very much for your testimony.

Dr. Ferris?

[Dr. Vanselow's prepared statement follows:]

ASSOCIATION OF ACADEMIC HEALTH CENTERS

Senate Committee on Finance

Subcommittee on Health

June 3, 1985

Hearing on Medical Education Pass-Through

Testimony by

Neal A. Vanselow, M.D.

Vice President for Health Sciences

University of Minnesota

Board Member

Association of Academic Health Centers

SUMMARY

- Currently Medicare makes no distinction between graduates of accredited American and Canadian medical, osteopathic, and dental schools, on the one hand, and graduates of foreign schools on the other. The AAHC recommends that savings in the Medicare funds that go to pay for teaching hospital residencies should be achieved first of all by discontinuing payments for residency positions filled by foreign medical school graduates. States with significant dependence on foreign medical school graduates for staffing certain hospitals should assume responsibility for paying these residents.

- AAHC recommends that Medicare reimbursement procedures and definitions for "direct" graduate medical education costs be continued as currently practiced, except that eligibility should be limited to the number of years currently required for initial board certification.

- AAHC proposes that the portion of residents' stipends eligible for Medicare reimbursement should be uniform for all specialties and all hospitals, with adjustments for area cost of living and small increments for seniority.

- AAHC supports maintaining unchanged current provisions for the reimbursement of teaching costs of health professionals other than physicians.

- AAHC opposes any cuts in the "indirect cost" proxy until more is known about the factors causing these costs. Should some cuts be considered unavoidable, the proxy formula should not be cut below the 9 percent per .1 resident per bed.

- Legislation stipulating number and types of health professionals to be trained, quotas for specialties, length of training, curriculum, etc., would constrain the teaching institutions in responding to health manpower market changes and should be avoided.

Senator Durenberger, and members of the Committee, I am Dr. Neal A. Vanselow, Vice President for Health Sciences at the University of Minnesota. I am also a member of the Board of Directors of the Association of Academic Health Centers, and it is in this capacity that I am pleased to have the opportunity to speak today on the subject of graduate medical education.

The Board of Directors is the elected governing body of the Association of Academic Health Centers. The Association is composed of approximately one hundred American and Canadian institutions of higher education, whose chief administrative officers -- presidents, chancellors, vice presidents for health affairs and others -- share with the deans of their respective health professions schools (medicine, dentistry, nursing, etc.) and with the directors of their principal teaching hospitals the responsibility for these institutions' educational, research, and patient care mission and for their fiscal stability.

The statements I will make represent the position of the Board of Directors of the Association.

STATEMENT OF PRINCIPLES

The cost of graduate medical education programs has traditionally been recognized by government and by private payors as an expense teaching hospitals should recover through charges for services rendered to patients. With the enactment of the recent Medicare legislation, and the introduction of the prospective payment system for Medicare patients, Congress has reaffirmed the legitimacy of financing graduate medical education through revenues from hospital patient services, by providing in the law means for the continuation of the pass-through of direct educational costs, as they apply to the Medicare program.

The current federal budget deficit and pressures to stabilize the Hospital Insurance Trust Fund have prompted a reexamination of graduate medical education financing through Medicare. Among the justifications advanced by those who propose that federal payments toward graduate medical education should be reduced is the argument that the current system of subsidies for resident training is open ended, and has thus helped produce a surplus in some specialties, without solving the problems of geographical and specialty maldistribution. Legislative approaches aimed at cutting the federal share of the costs have been proposed, ranging from arbitrary freezes of the amount Medicare would pay (regardless of actual costs) to elimination of payments to specialty programs perceived by some as not being needed for the care of Medicare patients.

While we recognize the need to balance federal receipts and outlays, we submit that hasty, excessive or highly targeted reductions in the funds which support graduate medical education could bring about long-term damage to valuable aspects of a system which has made American medicine preeminent in the world, and could constrain the ability of universities and hospitals to meet the health professional manpower requirements of the nation as new needs emerge.

We respectfully submit the following six principles for consideration by federal agencies and by Congress in approaching new legislative measures to regulate Medicare payments for graduate medical education:

1. Graduates of Foreign Medical Schools

The Medicare program currently makes no distinction between residency positions filled by graduates from the medical schools accredited by the Liaison Committee on Medical Education or by the Bureau of Professional Education of the American Osteopathic Association on the one hand, and graduates of foreign medical schools not accredited by the above bodies on the other.

While there may have been some justification for this practice in past years when the physician supply was felt to be less than needed, it is unnecessary now that there is near balance between number of residency positions offered in the United States and number of physicians graduating from accredited U.S. and Canadian medical schools.

We have long opposed the practice of allowing entry into the American health system of individuals with doubtful credentials, and firmly believe that:

a) The government should not continue to encourage the practice of accepting foreign medical graduates into accredited residency positions by funding these individuals' graduate medical education cost under Medicare or other programs.

b) The elimination of such U.S. government funding for foreign medical graduates' residency training in the United States would not impair the U.S. health care system, but would in fact improve the quality of its medical manpower pool.

At the present time, about 18 percent of the residency training positions in the United States are filled by physicians graduated from non-accredited schools. We submit that the elimination of Medicare payments for the costs incurred in training these individuals would produce most of the reduction sought in Medicare expenditures for graduate medical education, without any corresponding decline in the ability of the educational system to maintain a flow of quality physician manpower. In the few states in which certain types of hospitals still depend on foreign medical graduates for staffing, we recommend that the individual states assume the responsibility for paying these residents.

2. Support for Residency Training Leading to Initial Board Certification

We recognize that the current practice of indefinite support for residency training, including the entire term leading to subspecialty board certification, may represent an inducement for candidates to elect continuation of training into subspecialties, irrespective of manpower needs. We believe that once physicians achieve certification in a primary specialty (the length of time required varies with each specialty) financing of the continuation of their training in a subspecialty should be assumed by the trainees themselves or by others, but not by the federal government.

We strongly recommend that funding of residency training for the number of years now required for initial board certification of physicians and dentists be continued in essentially the same way as currently practiced, i.e., through reimbursement to the hospital of the expenditures now allowed under the "direct cost" definition. Further, in order that educational institutions be allowed more flexibility in training residents in ambulatory care settings, and so emphasize the primary care specialties, we recommend that the teaching hospitals be permitted discretion in the utilization of the funds they receive for graduate medical education.

3. Equalization of Residents' Stipends

We recommend: that the portion of the resident's stipend recognized eligible for Medicare reimbursement be the same for all residents in all hospitals, for all specialties, except for adjustments proportional to the cost of living index in different areas of the United States; that the uniform base be adjusted annually for changes in national cost of living indices; and that a modest amount be added for each year of seniority.

4. Educational Costs of Programs Other than Medicine

Teaching hospitals incur costs for the training of health professionals other than physicians, such as pharmacists, nurses, dentists, allied health professionals and others. These professionals are indispensable to the functioning of our health care system; support of their training is of critical importance, even though the amount of funds contributed by the federal government is small compared to those for graduate medical education.

We urge a continuation of current provisions for the reimbursement to hospitals of the teaching costs of educating health professionals other than physicians.

5. "Indirect Cost" Proxy

When Congress enacted the legislation which put in place a prospective payment system, it recognized that teaching hospitals bear extraordinary costs which are due to such factors as intensity of care, severity of illness, predominantly inner city location, disproportionate ratio of uncompensated care, etc. These characteristics, plus costs originating from the hospitals' teaching mission but not quantifiable under the "direct" cost rubric, led to the introduction of an adjustment to the per-admission (DRG) rate, which came to be called the "indirect cost" proxy.

Studies initiated since the enactment of the legislation, and to be completed in the near future, are attempting to identify the nature and extent of these extra costs. Information available to date indicates that the costs attributable to "teaching" are relatively small compared with those attributable to unusual "service" factors in teaching hospitals. Yet some mistakenly regard the "indirect cost" adjustment as another teaching cost pass-through, and argue for an immediate 50 percent reduction of the payments allowed under the formula.

We strongly urge Congress to leave the existing "indirect costs" proxy in place until the results of studies to clarify the factor causing these extra teaching hospital costs are completed, and appropriate new measures can be designed.

Should the necessity to reduce the national budget deficit make it mandatory that some savings be achieved this year from the Medicare "indirect costs" proxy, we strongly urge that the proxy formula not be cut below the 9 percent per .1 resident per bed. Preliminary information from studies now in process seem to indicate that this may be an appropriate level of support.

6. Control of Training Programs

We are concerned that in the process of seeking a solution to the cost problem Congress may inadvertently insert the federal government into areas of judgment traditionally reserved to the university. We hope that Congress will not cast into legislation the number and types of health professionals to be trained, quotas for specialties, length of training, curriculum, etc., under the guise of cost reduction or to stimulate a response to currently perceived market needs.

Health care in the United States is in a state of transition. Advances in clinical technology, flux in the supply of health professionals, new ways of organizing health services, the aging of our population, and changes in financial incentives for health care providers, are having a profound effect on patterns of patient care and utilization of services, and are influencing health professionals' career choices. It is not clear where all these changes will lead. Some trends seem predictable, such as trends to more ambulatory care, but, specifically what health care will be offered, in what manner, and by what types of specialists is uncertain. It is possible that new technologies and new organizational forms of providing patient care may emerge which will change current methods of delivering health care and will perhaps increase the need for some types of health professionals and specialists that may seem to be in oversupply at present.

In this unpredictable environment we do not believe it possible to define future manpower needs with any precision, and for this reason we urge that maximum flexibility be left to the teaching institutions responsible for the residency programs to modify programs and curricula as changes take place in the health system. Legislative initiatives which would freeze funding in relation to currently perceived needs or which are designed to provide stimuli for satisfying the current demands of the marketplace ignore the time lag (considerable in some cases) for the training of competent professionals.

Thank you for your attention. I will be pleased to answer your questions concerning the statements I have just made.

STATEMENT OF THOMAS FERRIS, M.D., CHAIRMAN, DEPARTMENT OF MEDICINE, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN, ON BEHALF OF THE ASSOCIATION OF PROFESSORS OF MEDICINE, WASHINGTON, DC

Dr. **Ferris**. Good morning, Senator Durenberger.

I am Dr. Thomas F. Ferris, chairman of the Department of Internal Medicine at the University of Minnesota School of Medicine. My testimony is on behalf of the Association of Professors of Medicine, the organization that represents the chairpersons of the departments of internal medicine in the nation's medical schools.

In addition to medical school education, our departments are responsible for programs that train residents in the field of internal medicine and its subspecialties, such as cardiology and oncology. Currently there are over 19,000 residents in internal medicine and approximately 7,000 subspecialty residents who together constitute more than 25 percent of the total number of graduate trainees in the various fields of medicine. Given these significant educational responsibilities, our association has a particularly keen interest in issues related to residency training. Accordingly, I am accompanied today by the president of the Association of Professors of Medicine, Dr. Jay Stein, to my left, and Dr. Norton Greenberger from the University of Kansas Medical Center to my right. We appreciate this opportunity to appear before this committee to offer the association's views regarding the financing of graduate medical education.

At its annual membership meeting in early May, the association adopted a formal position paper regarding this important issue. The statement, which is attached for your review, offers a specific proposal that should serve to reduce the cost and enhance the quality of graduate medical education.

The association recommends that (1) for all the fields of medicine, current mechanisms of support for graduate medical education should be continued but should pay only for the training of graduates of LCME, accredited medical schools. In the field of internal medicine, current mechanisms should continue to support the training of graduates of LCME accredited medical schools during three years of medical residency.

Third, patient care reimbursement mechanisms should continue to support training in the subspecialties of internal medicine but should pay only for 1 year of training for each individual and should be restricted to graduates of LCME accredited medical schools.

The implementation of this proposal would result in an 18 percent reduction in the cost of graduate training without disrupting those residency programs which currently offer high-quality education attractive to graduates of LCME accredited medical schools.

In addition, it would address manpower concerns by reducing the total number of physicians trained and by shifting funds away from medical subspecialty programs while maintaining adequate support for training in general internal medicine.

I would also point out that this proposal requires neither drastic organizational changes in the financing of graduate medical education nor the establishment of new Federal, State, or local administrative structures.

Against this background I would like to offer the association's views regarding S. 1158, a proposal to amend the Social Security Act with respect to Medicare payments for the direct costs of approved educational activities. We would like to take this opportunity to commend Senators Dole, Durenberger, and Bentsen for their efforts to thoughtfully address an extraordinarily complex issue and for their willingness to engage in a dialog with the academic community regarding the fiscal concerns and manpower issues which so clearly require our attention.

Foremost, we are gratified by their recognition of the need to assure that changes in relevant Medicare policies are implemented in a gradual orderly manner so that our ability to maintain a continuous supply of well-trained physicians is not jeopardized.

Our concerns about S. 1158 focus primarily on the provision which states "the Secretary shall not recognize as reasonable the cost of training an individual resident beyond the lesser of (1) 5 years, or (2) the minimum number of years required for initial board certification in the specialty for which the resident is preparing." This provision would preclude support for residencies in the subspecialties of internal medicine, because these areas require 2 to 3 years of training subsequent to the 3-year residency required for initial board certification in internal medicine. The Association of Professors of Medicine questioned why the medical subspecialties have been singled out for a total withdrawal of Medicare training support.

We respectfully request that the members of this committee consider this aspect of S. 1158 in light of the following:

One, a 1981 study sponsored by the Robert Wood Johnson Foundation and the Health Resources Administration indicated that 29 percent of the outpatients seen by medical subspecialists are age 65 or over, compared to 28 percent for general internists and 11 percent for family physicians.

The report also shows that over a 3-day period both general internists and medical subspecialists see an average of 11 patients age 65 or over. Clearly, practitioners of the subspecialties of internal medicine are providing the care required by Medicare beneficiaries to the same important extent as general internists.

Two, growing numbers of departments of internal medicine are establishing advanced training programs in the field of geriatrics, the study of diseases which afflict the elderly. The American Board of Internal Medicine recently announced that it intends to offer a certificate of added qualification in this field. However, under the provisions of S. 1158, advanced training in geriatrics would no longer be supported by Medicare.

Three, we are not aware of any data to indicate that medical subspecialists will represent a particularly large proportion of the projected surplus of physicians. In fact, as shown in table 1, the Graduate Medical Education National Advisory Committee projected larger surpluses in other specialties and in several surgical subspecialties which would continue to receive full training support under the provisions of S. 1158.

There are significant data to indicate that medical subspecialists devote a considerable portion of their time to primary care. In 1979, Mendenhall, Tarlov, and others reported the results of a nationwide survey from which they concluded that subspecialists in internal medicine:

> Are assuming ongoing and comprehensive responsibility for the management of very substantial numbers of their patients and have an appreciable commitment to entry-level care. These factors must be considered in future proposals to ameliorate inequities in the availability of primary care physicians.

End of quote from that study.

The data from this particular study indicated that office based practitioners in six of the nine medical subspecialties spend more than 50 percent of their time providing primary care.

In summary, the Association of Professors of Medicine appreciate the willingness of the sponsors of S. 1158 and the members of this committee to thoughtfully address the issue of financing graduate medical education. We respectfully request your consideration of our recommendation that the bill be modified to allow 1 year of support for advanced training in the subspecialties of internal medicine and related fields such as geriatrics.

Thank you.

Senator DURENBERGER. Thank you very much.

Senator Dole.

Senator DOLE. I have no questions at this time.

[Dr. Ferris' prepared statement follows:]

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TESTIMONY BEFORE THE

SENATE COMMITTEE ON FINANCE

JUNE 3, 1985

PRESENTED BY

Thomas F. Ferris, M.D.

Professor and Chairman

Department of Medicine

University of Minnesota Medical School

RECOMMENDATIONS:

1. For all of the fields of medicine, current mechanisms for support of graduate medical education should be continued but should pay only for the training of graduates of LCME-accredited medical schools.

2. In the field of internal medicine, current mechanisms should continue to support the training of graduates of LCME-accredited medical schools during three years of medical residency.

3. Patient care reimbursement mechanisms should continue to support training in the subspecialties of internal medicine but should pay only for one year of training for each individual and should be restricted to graduates of LCME-accredited medical schools.

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Good morning. I am Dr. Thomas F. Ferris, chairman of the department of internal medicine at the University of Minnesota Medical School. My testimony is on behalf of the Association of Professors of Medicine (APM), the organization that represents the chairpersons of the departments of internal medicine in the nation's medical schools. In addition to medical student education, our departments are responsible for programs that train residents in the field of internal medicine and its subspecialties, such as cardiology and oncology.* Currently, there are over 19,000 residents in internal medicine and approximately 7,000 subspecialty residents who together constitute more than 25% of the total number of graduate trainees in the various fields of medicine. Given these significant educational responsibilities, our Association has a particularly keen interest in issues related to residency training. Accordingly, I am accompanied today by the president of the APM, Dr. Jay H. Stein from the University of Texas Health Science Center in San Antonio, and the president-elect, Dr. Norton J. Greenberger from the University of Kansas Medical Center. We appreciate this opportunity to appear before this Committee to offer the Association's views regarding the financing of graduate medical education.

At its annual membership meeting in early May, the Association adopted a formal position paper regarding this important issue. The statement, which is attached for your review, offers a specific proposal that should serve to reduce the costs and enhance the quality of graduate medical education. The Association recommends that:

1. For all of the fields of medicine, current mechanisms for support of graduate medical education should be continued but should pay only for the training of graduates of LCME-accredited medical schools.

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* See page 6 for a description of the nine medical subspecialties

2. In the field of internal medicine, current mechanisms should continue to support the training of graduates of LCME-accredited medical schools during three years of medical residency.
3. Patient care reimbursement mechanisms should continue to support training in the subspecialties of internal medicine but should pay only for one year of training for each individual and should be restricted to graduates of LCME-accredited medical schools.

The implementation of this proposal would result in an 18% reduction in the costs of graduate training without disrupting those residency programs which currently offer high-quality education attractive to graduates of LCME-accredited medical schools. In addition, it would address manpower concerns by reducing the total number of physicians trained and by shifting funds away from medical subspecialty programs while maintaining adequate support for training in general internal medicine. I would also point out that this proposal requires neither drastic organizational changes in the financing of graduate medical education nor the establishment of new federal, state or local administrative structures.

Against this background, I would like to offer the Association's views regarding S. 1158, a proposal to amend the Social Security Act with respect to Medicare payments for the direct costs of approved educational activities. We would like to take this opportunity to commend Senators Dole, Durenberger, and Bentsen for their efforts to thoughtfully address an extraordinarily complex issue and for their willingness to engage in a dialogue with the academic community regarding the fiscal concerns and manpower issues which so clearly require our attention. Foremost, we are gratified by their recognition of the need to assure that changes in relevant Medicare policies are implemented in a gradual, orderly manner so that our ability to maintain a continuous supply of well-trained physicians is not jeopardized.

Our concerns about S. 1158 focus primarily on the provision which states that the Secretary shall not recognize as reasonable the costs of training an individual resident beyond the lesser of: 1) five years, or 2) the minimum number of years required for initial board certification in the specialty for which the resident is preparing. This provision would preclude support for residencies in the subspecialties of internal medicine because these areas require 2-3 years of training SUBSEQUENT TO the three-year residency required for initial board certification in internal medicine. The Association of Professors of Medicine questions why the medical subspecialties have been singled out for a TOTAL withdrawal of Medicare training support. We respectfully request that the members of this Committee consider this aspect of S. 1158 in light of the following:

- A 1981 study sponsored by the Robert Wood Johnson Foundation and the Health Resources Administration indicated that 29% of the outpatients seen by medical subspecialists are age 65 or over, compared to 28% for general internists and 11% for family physicians. The report also showed that over a three-day period, both general internists and medical subspecialists see an average of 11 patients age 65 or over.[1] Clearly, practitioners of the subspecialties of internal medicine are providing the care required by Medicare beneficiaries to the same important extent as general internists.

- Growing numbers of departments of internal medicine are establishing advanced training programs in the field of geriatrics, the study of diseases which afflict the elderly. The American Board of Internal Medicine recently announced that it intends to offer a "certificate of added qualifications" in this field. However, under the provisions of S. 1158, advanced training in geriatrics would no longer be supported by the Medicare program.

- We are not aware of any data to indicate that medical subspecialists will represent a particularly large portion of the projected surplus of physicians. In fact, as shown in Table 1, the Graduate Medical Education National Advisory Committee projected larger surpluses in other specialties and in several surgical subspecialties which would continue to receive full training support under the provisions of S. 1158.

- There are significant data to indicate that medical subspecialists devote a considerable portion of their time to primary care. In 1979, Mendenhall, Tarlov et al reported the results of a nationwide study from which they concluded that "subspecialists in internal medicine are assuming ongoing and comprehensive responsibility for the management of very substantial numbers of their patients and have an appreciable commitment to entry-level care. These factors must be considered in future proposals to ameliorate inequities in the availability of primary care services."[2] Data from this particular study indicated that office-based practitioners in 6 of the 9 medical subspecialties spend more than 50% of their time providing primary care to their patients.

- It was noted at the time of the introduction of S. 1158 that training programs in the medical, pediatric, and surgical subspecialties include a specified period of time for organized research and that the Medicare program was not intended to support non-service-related research activities. While it is true that programs in the medical subspecialies frequently require one year of research experience, such training is not funded by Medicare and would not be so supported under our Association's proposal.

  In internal medicine, most subspecialty programs require either two years of clinical (patient care) experience or one year of clinical experience and one year of research training. If a period of research is required, this component is most often supported by outside sources such as the National Institutes of Health, private foundations, or voluntary health groups such as the American Heart Association and the National Kidney Foundation. It is specifically because of this multi-source funding arrangement that our Association's proposal would serve to effectively control both the quantity and quality of subspecialty training. If Medicare and other payers continue to provide support for one year of medical subspecialty training, as we advocate, only those high-quality programs able to attract supplemental support for the additional year of required training could continue. On the other hand, if Medicare support for subspecialty training is totally withdrawn, as proposed in S. 1158, we are certain that many excellent programs would be dismantled.

In summary, the Association of Professors of Medicine appreciates the willingness of the sponsors of S. 1158 and the members of this Committee to thoughtfully address the issue of financing graduate medical education. We respectfully request your consideration of our recommendation that the bill be modified to allow one year of support for advanced training in the subspecialties of internal medicine and related fields such as geriatrics. Drs. Greenberger and Stein and I would be happy to respond to any questions.

THE SUBSPECIALTIES OF INTERNAL MEDICINE

Allergy/Immunology:	the study of allergic diseases such as asthma
Cardiology:	the study of the heart and its diseases including coronary artery disease
Endocrinology/Metabolism:	the study of hormonal disorders such as diabetes mellitus
Gastroenterology:	the study of the diseases of the stomach and intestines including disorders such as peptic ulcers
Hematology/Oncology:	the study of disorders of the blood and cancers
Infectious Diseases:	the study of infections and communicable diseases such as tuberculosis
Nephrology:	the study of kidney diseases including the dialysis treatment of chronic renal disease
Pulmonary Medicine:	the study of lung diseases such as emphysema
Rheumatology:	the study of rheumatic diseases such as arthritis

TABLE 1

SHORTAGES AND SURPLUSES BY SPECIALTY AS PROJECTED BY THE GMENAC PANEL

(The subspecialties of internal medicine are indented. See page 6 for definitions.)

Specialty	Years of Training Required	Projected (Shortage) Surplus	Fully Supported Under S. 1158?
Gen'l Psychiatry	3-4	(8,000)	Yes
Child Psychiatry	4	(4,900)	Yes
Emergency Medicine	3	(4,250)	Yes
Preventive Medicine	3	(1,750)	Yes
Anesthesiology	4	(1,550)	Yes
Physical Medicine and Rehabilitation	3	(800)	Yes
IM-Hematology/Oncology	5-6	(700)	No
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IM-Gastroenterology	5	400	No
Dermatology	4	400	Yes
Otolaryngology	5	500	Yes
Thoracic Surgery	7	850	No
IM-Infectious Diseases	5	1,000	No
IM-Allergy/Immunology	5	1,000	No
Plastic Surgery	5	1,200	Yes
IM-Rheumatology	5	1,300	No
Urology	5	1,650	Yes
IM-Endocrinology/Metabolism	5	1,800	No
IM-Nephrology	5	2,100	No
Neurosurgery	6-7	2,450	No
Family Practice	3	3,100	Yes
Neurology	3	3,150	Yes
IM-Pulmonary Medicine	5	3,350	No
Pathology	1-4	3,350	Yes
Internal Medicine	3	3,550	Yes
Ophthalmology	4	4,700	Yes
Pediatrics	3		Yes
Pediatric Subspecialties	5	4,950	No
Orthopaedic Surgery	5	5,000	Yes
IM-Cardiology	5	7,150	No
Radiology	3-4	9,800	Yes
Obstetrics/Gynecology	4	10,450	Yes
General Surgery	5	11,800	Yes

Source: Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services. Volume i. September 30, 1980.

REFERENCES

1. SCHLEITER MK. National study of internal medicine: Phase III. Analysis of 1976-77 resident cohort currently in practice. Final Report. Washington, DC: Health Resources Administration.

2. MENDENHALL RC, TARLOV AR, GIRARD RA, MICHEL JK, RADECKI SE. A national study of internal medicine and its specialties: II. Primary care in internal medicine. Annals of Internal Medicine. 1981; 94:275-287.

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FINANCING GRADUATE MEDICAL EDUCATION:
A PROPOSAL
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The Association of Professors of Medicine (APM) is the organization that represents the chairpersons of departments of internal medicine in the nation's medical schools. In addition to medical student education, our departments are responsible for graduate programs that train physicians in general internal medicine and its subspecialties (e.g., cardiology, oncology). Currently there are over 19,000 internal medicine residents and approximately 7,000 subspecialty residents who together constitute more than 25% of the total number of graduate trainees in all the various fields of medicine. Given these significant educational responsibilities, members of the APM are keenly interested in issues related to graduate medical education (residency training).

The Association is aware that mechanisms and levels of financial support for graduate medical education are being re-examined in the light of the need to control government spending for health care and a predicted surplus of physicians in some specialty areas. The APM would like to offer a proposal that will address these concerns without diminishing the current high quality of education and patient care provided by teaching programs.

BACKGROUND

Current mechanisms for support of graduate medical education have been successful.

- High quality graduate education has been available to maintain the supply of physicians required by the nation's health care system.
- Graduate trainees provide a high quality of medical care to patients in American teaching hospitals. These institutions are major sources of health care to very sick patients and to medically indigent people.
- The current system for support of the cost of graduate medical education through medical care reimbursement mechanisms has allowed flexibility in shaping individual medical training programs, in keeping with the American tradition of local autonomy in education.
- The cost of graduate medical education is a small fraction of the overall cost of health care. Direct costs are less than 1% of health care expenditures. Current reimbursement for indirect costs includes factors weighting for the increased intensity of illness of patients in the nation's teaching hospitals; even allowing for this overestimate, indirect costs are about 4% of total medical care costs.

In view of the above, the APM urges that any changes in the mechanism for supporting graduate medical education be made carefully, thoughtfully and with due consideration to the dangers of damage to a vital national priority: a continuous supply of well-trained physicians. The APM also urges that due consideration be given to the uncertainty of even the most carefully developed projections of the need for physicians. It was in response to a projection in the 1960's that there would be a shortage of doctors that the federal government encouraged development of new medical schools and increased enrollment in existing institutions. The number of medical school graduates more than doubled between 1960 and 1983, with the result that an oversupply of physicians is now projected.

The APM offers a proposal which responds to the need for controlling costs of health care and to the current projections of excess numbers of physicians without requiring drastic organizational changes in the financing of graduate medical education.

PROPOSAL

1. For all of the fields of medicine, current mechanisms for support of graduate medical education should be continued but should pay only for the training of graduates of LCME-accredited medical schools.

2. In the field of internal medicine, current mechanisms should continue to support the training of graduates of LCME-accredited medical schools during three years of medical residency.

3. The subspecialties of internal medicine require 2-3 years of training subsequent to residency in internal medicine. Support from patient care reimbursement mechanisms should be continued but should pay only for one year of training for each individual and should be restricted to graduates of LCME-accredited medical schools.

ADVANTAGES OF THE PROPOSAL

Certain advantages of this proposal are worth attention:

- Costs of graduate medical education support would be decreased immediately by about 18%.

- Support for training in the subspecialties of internal medicine would be decreased, thereby reducing expenditures for such programs and influencing trainees to choose careers in primary care.

- No new federal, state or local administrative structures would be required.

- All graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) would be able to obtain the graduate medical education required for independent medical practice. In addition, all current graduate training programs able to offer high quality education attractive to graduates of LCME-accredited medical schools could continue without disruption.

- Eighteen percent of the more than 72,000 residents in training in 1984 are graduates of schools not accredited by the LCME. These physicians trained outside of the United States represent a substantial portion of the projected surplus of doctors in this country. By eliminating support from medical care reimbursement mechanisms for these trainees, expenditures for medical education and the trend towards an oversupply of physicians would be reduced substantially.

- The Association's proposal would not preclude foreign medical graduates from obtaining residency training positions supported financially by sources other than medical care reimbursement mechanisms. Accordingly, the United States can continue to play an appropriate role in the education of physicians for underserved countries.

STATEMENT OF NORTON J. GREENBERGER, CHAIRMAN OF THE DEPARTMENT OF MEDICINE, UNIVERSITY OF KANSAS MEDICAL CENTER, KANSAS CITY, KS, AND PRESIDENT-ELECT OF THE ASSOCIATION OF PROFESSORS OF MEDICINE, WASHINGTON, DC

Dr. **Greenberger**. Well, I fully subscribe to the statement that Dr. Ferris has just read, and I think I will reemphasize the issue that, under the current proposal, there would appear to be a total withdrawal of funds for the support of the specialties in internal medicine.

With reference to the programs at the University of Kansas Medical Center, we have 369 residents; 102 are in internal medicine and its subspecialties, and of that 102 there are 30 in subspecialty training. These are in accord with the national averages.

Senator **Dole**. Mr. Chairman, I appreciate very much your having these hearings on the bill that three of us did introduce just recently. I have a statement that I would ask be made a part of the record.

Senator **Durenberger**. It will be made a part of the record.

Senator **Dole**. I want to thank Mr. Staples for his assistance, and we look forward to addressing some of the concerns you have raised concerning our legislation. This is an important area. Recognizing that we do have a budget deficit and need to make reductions, we will try to reach the best consensus that we can in the best way we can.

Senator **Durenberger**. Let me start first with the U.S. FMG situation, and ask the witnesses from the first two associations whether my impression is correct. Is it your recommendation that we eliminate Medicare financial support for both alien FMG's and U.S. citizen graduates of foreign medical schools? Is that a correct interpretation, Dr. Weston?

Dr. **Weston**. That is a correct interpretation, with the qualifier of a phaseout of the foreign FMG because of some of the problems of access with innercity hospitals and the need to get more quality residents into those facilities.

Senator **Durenberger**. Dr. Vanselow?

Dr. **Vanselow**. Our position would be the same, Senator Durenberger.

Dr. **Ferris**. That is our position, also.

Senator **Durenberger**. All right. Let me ask you, then, a slightly related question that goes to your views as practitioners.

I take it part of the problem is the problem that somebody here said earlier—I don't know whether it was Mr. Hatch or not—that the available residencies across the country about equal the number of U.S. medical college medical graduates, and anybody who comes in from a foreign medical college is at this point competing for available space. Is that the correct premise on which each of the associations lay their objections?

Dr. **Weston**. I do not believe our position is totally on that basis. We are looking at the quality issue. Our numbers would show about 1.3 residency position openings for each U.S. medical school graduate. In some specialties, it is very competitive, but for the most part an American trained graduate can compete effectively for a residency slot. The real issue is, if we are talking about manpower supply and cutting back funding of residency training, where do we put our dollars? I don't think any of us are opposed to helping faculty development for developing countries, but that should be a policy approach. That's where we are coming from, or that is where the AAMC is coming from.

Senator DURENBERGER. All right.

Dr. Vanselow.

Dr. VANSELOW. Senator Durenberger, I might just outline our rationale. I mentioned two things before, manpower and the quality issue. First of all, we believe that schools in this country can meet manpower needs and that the quality is better.

What we are finding is that schools in this country are under tremendous pressure to decrease class size. At the University of Minnesota you know we have already done that.

What we are afraid will happen, because foreign schools are not under that pressure, is that the students who cannot get into United States and Canadian schools will simply go to foreign schools, and in effect we will be substituting well-trained physicians with physicians who are not trained as well. That bothers me. It is very hard to get faculties to support reduction in class size as long as the foreign schools are not under any pressure to do the same thing.

Senator DURENBERGER. Dr. Ferris?

Dr. FERRIS. Senator Durenberger, there are still about 4,000 more residency positions offered each year in the United States than there are graduates of LCME schools. So there still is an opportunity for foreign medical graduates.

Senator DURENBERGER. Could I ask one of you to comment on the alternatives? If quality is the issue, what are the alternatives presently available to this, which is a "defunding" in effect? Are there not present in the current system some quality assurance mechanisms that we might be able to use?

Dr. Weston?

Dr. WESTON. Well, the whole residency-review system could be a mechanism that potentially could address that issue by the standards they would put in of what kind of training an individual would have to have before he or she came into the residency program. I think you are seeing this issue surface so dramatically at this point in time because there are many suggestions that even cut back on undergraduate enrollments in American medical schools.

I probably am more adamant than many of my fellow deans. I find it almost immoral that we will send kids off to the Caribbean offshore medical schools, the proprietary medical schools, as a way to meet our manpower needs in a country that has the capability of training quality individuals. It is not the young people who are immoral; the system is immoral.

Senator DURENBERGER. Can you assure us that every foreign medical school generally produces graduates of a lesser quality than every American school? Are there not some schools in this country that——

Dr. WESTON. I am sure there are marginal programs, but I think the accrediting process here is much more stringent. There are some quality programs around the world; I would not presume to be an expert on all of those. We have some outstanding foreign medical graduates on our faculty. Almost every person here probably has some. However, I think the issue has to be dealt with as a broad policy issue.

Senator **Durenberger**. Yes?

Mr. **Staples**. Mr. Chairman, I think you also have to really emphasize the public pressure now for the reduction of first-year places in our U.S. medical schools. It seems kind of foolish for us to reduce our first-year places in what we consider quality education and accept the foreign medical graduate into our residency programs.

Senator **Durenberger**. Other people in this body and the other have proposals to reform Medicare funding of graduate medical education, seem to have taken two tacks: One would make Medicare payment dependent upon having a fixed proportion of residents in primary care and a fixed proportion of graduates of United States and Canadian medical schools, and a second proposal would fund primary care residents at a higher level than specialty residents and would establish a national rate for stipends and fringe benefits for residents. Would any of you care to comment on these other approaches to GME reform and compare them with the provisions in S. 1158?

Dr. Vanselow?

Dr. **Vanselow**. Senator Durenberger, I am not in a position to comment in detail on all the other proposals, but several of them that I have seen would not really allow the marketplace to operate and would cast a fairly rigid form into law, quotas for various specialties, and so on.

I wish I could say that anybody sitting on any day had the wisdom to deal not only with the present but the future. I am not quite sure about that. I think our organization believes very strongly that the marketplace ought to make these decisions, and we believe S. 1158 will let the marketplace do that.

Senator **Durenberger**. Any other comments? Dr. Stein?

Dr. **Stein**. Yes. I would just like to briefly comment and reiterate again, from Dr. Ferris' testimony, the tricky nature of the definition of "primary care." Again, in fields that are being tagged as "subspecialists," when one does studies—and I am sure this isn't just true in internal medicine—that those individuals are indeed performing a great percentage of their time, in many instances, in primary care, taking care of day-to-day activities, and they just don't do their subspecialties. So there are problems in categorizing individuals because of this, I think.

Senator **Durenberger**. Thank you very much.

Dr. Weston?

Dr. **Weston**. I think there is one other dimension that I probably should identify, maybe speaking as an individual rather than for the AAMC, that some of the other bills that I have seen are starting to raise, and that is the issue of making funding available for alternative sites and not just the inpatient setting, which is a problem as you start to shift towards future directions of graduate education.

I think all of us feel that ambulatory settings, even nursing homes, et cetera, become a basis. And I think that shift is important and, once again, keeps the marketplace phenomena in place.

Senator **Durenberger**. Thank you.

Senator Dole?

Senator **Dole**. I don't have any questions at this time.

Senator **Durenberger**. Let me not leave you without one other question which relates to part B billing practices.

Dr. Weston, in your testimony you suggest that we amend S. 1158 to allow residents that will not be supported by Medicare to bill under part B. Our interest is in your perception of the current part B billing practices of these fifth year and beyond residents and your estimate of the net cost or saving to Medicare of the change that you propose.

Dr. **Weston**. Our perception at the present time is that any billing is limited, but it is not absolutely no billing, because it depends a little bit on whether someone is in a fellowship versus a residency. I could use the example of potentially the internist—and correct me—in cardiology versus a thoracic surgeon. Some cardiology fellows might be billing at the present time, and legally be billing because they are not a resident; but it is minimal at the present time and it's technical, if I can put it that way. The actual savings? I will have the staff get the dollar figure for you; I couldn't give that to you.

[The information follows:]

aamc association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

June 21, 1985

Senator David Durenberger
Chairman, Subcommittee on Health
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Dear Senator Durenberger:

When the AAMC testified before the Subcommittee on Health on June 3, our statement included the following recommendation:

> The AAMC recommends amending S.1158 to allow Part B bills to be rendered for physician services provided by individuals in residency years which may not be included in a hospital's costs.

In response to a question, Dr. Weston indicated AAMC staff would attempt to estimate the dollar impact of this recommendation.

AAMC staff do not have the data necessary to make an adequate estimate of the Medicare expenditures that would accompany implementation of this recommendation. To reasonably estimate the amount, the following data items are needed.

a. total of residents beyond initial board eligibility

b. average number of billable services provided by advanced residents which are not also billed by an attending physician

c. average Medicare payment per billable service.

At a minimum, separate estimates should be prepared for advanced surgical residents, advanced medical residents in procedural services, and advanced medical residents in non-procedural services.

The Association regrets that it is unable to estimate these data items, but any estimate we would provide could be substantially incorrect. Thus, we prefer not to submit data. I have, however, enclosed the most recent AAMC data on the revenue sources used to support clinical fellows. Physician fee revenue does support 9% of these trainees.

Sincerely,

John A. D. Cooper

John A.D. Cooper, M.D.

JADC/mrl

cc: Edgar R. Danielson
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Table 81

Percentage Distribution of Funding Sources Used to Pay Hospital Costs of Housestaff Stipends and Fringe Benefits, 1983-84 NATIONWIDE (Excluding VA Hospitals)

	Source of Revenue	
Funding Source	Residents	Clinical Fellows
Patient Revenues and General Operating Appropriations	81.10%	60.92%
State Appropriations Earmarked for Housestaff Expenses	4.98	2.30
Municipal Appropriations Earmarked for Housestaff Expenses	1.19	0.64
Veterans Administration Appropriations	1.98	4.04
Physician Fee Revenue	0.60	9.03
Medical School/University Funds	1.91	2.35
NIH	0.29	8.75
Other Federal Agencies	0.27	0.88
Endowment Income	0.03	0.52
Foundation Grants, Voluntary Agencies	0.43	5.40
Other	7.23	5.18
TOTAL	100.00%	100.00%
Number of Hospitals	280	97

Dr. WESTON. It is a sticky issue. We deliberated around this a long time. You have the potential to have individuals in the training setting that are delivering patient care. We are not going to reimburse them by the usual mechanism; we are not going to reimburse them by the other mechanism. It is like somewhere down the road, 5 years out, you take the vow of poverty or something for 2 years to go have your training. What do you do with these people? I mean, how do you justify them? We don't think it is just simple as our recommendation; it is a complex issue that we would love to work with your staff on.

Senator DURENBERGER. All right.

Dr. Ferris, I think I heard Gene Staples in his comments acknowledge the ease with which specialty boards extend the educational requirements, and that's sort of been an observation I have picked up just listening to people around the country. So let's not blame him; he just reminded me of that fact.

Would you react to that, any one of the three of you react to that? And particularly in light of your proposal that we need to extend the funding for certain of the categories of internal medicine subspecialties. Aren't we just opening the door for the same old thing to take place all over again?

Dr. FERRIS. Senator, those extensions are really not based on whimsy or in a fashion that is not based upon need. Medicine is just becoming so complex that even in general internal medicine there are physicians who take 5 years of training. In other words, there are fellowships in general internal medicine now that individuals will do after completing 3 years of internal medicine, and there are individuals who by the definition you are proposing are still generalists; they are not specialists. And this is happening in other fields like cardiology, where they feel that, rather than 2 years of training being sufficient, that 3 is needed for being a competent cardiologist. And that is true. In my own particular area of nephrology one could certainly make the argument that, although the board requirement now is 2 years, it probably should be 3.

It is not a matter of just trying to extend this infinitely, but it is just a realization of the complexity of medical training.

Senator DURENBERGER. I don't want to prolong the discussion today on this subject, but I think it is incumbent upon those of you who represent the specialties to demonstrate to us lay people the fact that just because more knowledge is either available or required, that that automatically translates into adding a month, a quarter, a semester, or whatever. It never seems, at least until recently, to translate into changing the mix of education within the same period of time. All you do—it appears at least from the outside—is just add on, add on, add on.

And again, the reality of the change in the way physicians practice medicine, in larger groups and so forth, doesn't yet seem to be reflected in the add-on process for the specialties and subspecialties.

There is no need this morning to comment on that, but I think it would be helpful if all of you who are involved in this process would just react perhaps in writing to add to the record of this hearing. It is not that we don't welcome your comments about the subspecialties, but it is a point that I think needs to be clarified.

Well, gentlemen, thank you all very much for your testimony. I appreciate it very much.

Our next witnesses are a panel consisting of Dr. Louis Kettel, the dean of the University of Arizona College of Medicine and vice chairman of the Section on Medical Schools, on behalf of the AMA; Dr. Clement Sledge, chief of the department of orthopedic surgery at Harvard Medical School; Dr. Robert Ruberg, associate professor of surgery at Ohio State University College of Medicine, on behalf of the American Society of Plastic and Reconstructive Surgeons; Dr. George Sheldon, chief, department of surgery, University of North Carolina; and Dr. Edward Hook, president of the American College of Physicians in New York.

We welcome all of you, and your statements will be made part of the record. Let me just again take the occasion between these panels of experts to express our personal appreciation to all of the medical and hospital groups for the large amount of very honest effort that has been put into helping us deal with the issue of graduate medical education.

So let us begin the testimony with Dr. Kettel.

STATEMENT OF LOUIS J. KETTEL, M.D., DEAN OF THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE AND VICE CHAIRMAN OF THE SECTION ON MEDICAL SCHOOLS, TUCSON, AZ, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR OF AMA'S DIVISION OF LEGISLATIVE ACTIVITIES

Dr. KETTEL. Thank you, Senator Durenberger and Chairman Dole.

My name is Louis Kettel. I am vice chairman of the Section on Medical Schools of the American Medical Association. I am also dean of the College of Medicine at the University of Arizona. Accompanying me is Harry Peterson, director of the AMA's Division of Legislative Activities.

The AMA is pleased to have the opportunity to testify concerning the financing of graduate medical education and on Senate bill 1158.

The AMA is very concerned over proposals to inappropriately reduce Federal support for graduate medical education. Such proposals, including the administration's budget request and action by the Senate and the House in passing budget resolutions, appear to be motivated by arbitrary budget targets without regard for the serious adverse consequences which may result from a reduction in Federal assistance for graduate medical education.

Mr. Chairman, the existing system, as you have heard, is complex indeed. Changes must be carefully evaluated and considered, since an ill-advised change could threaten the Nation's ability to train qualified physicians to meet our Nation's health needs in the future.

The AMA believes strongly that an in-depth study of the financing of graduate medical education should be undertaken before Congress makes substantial cuts. To this end, the AMA has established an ad hoc panel which will conduct a thorough study of the financing of graduate medical education.

I will now outline our views concerning S. 1158:

The AMA believes that the 1-year freeze on direct medical education costs proposed in S. 1158 could have an adverse impact on patient care in teaching institutions. Moreover, the particular cap proposed, being set on a hospital-by-hospital basis, fails to reflect changes constantly occurring in the number of residency positions. If any cap is to be initiated, a cap-per-position would appear more equitable.

Nevertheless, the freeze proposed in S. 1158 is preferable to the recently published Health Care Financing Administration's proposed rule, as its level of reimbursement has a limitation to 1 year.

The AMA recognizes the serious threat to the Nation's long-term economic health posed by the huge Federal budget deficits which have been projected for the foreseeable future. However, we oppose cuts in health programs that require such programs to bear a disproportionate burden of deficit reduction. But we would not oppose a freeze on direct medical education costs for a 1-year period if it is part of an across-the-board freeze on all domestic and defense spending.

While we have concerns, we believe that the provision limiting the number of residency years reimbursed by Medicare has merit in addressing the graduate medical education funding. It attempts to establish a compromise between the existing open-ended reimbursement arrangement and proposals that would more severely curtail the number of residency years reimbursed by Medicare. Under this provision, primary care, general surgery, and other residencies could be covered.

However, this provision would also have the effect of denying Medicare reimbursement for direct medical education costs during the last years of training for residents specializing in some surgical specialties as well as residents training in subspecialties such as pediatrics and internal medicine.

We recognize the objective sought and appreciate the work of the sponsors in formulating this proposal, but we believe the provision should not be adopted without assurances that adequate funding will remain available.

In light of the huge Federal budget deficit, the AMA supports the intent of the provision whereby Medicare payment would be eliminated for the costs of residency training for citizens of foreign countries who have not graduated from U.S. medical schools. The association has supported and continues to support the national policy of making available training for foreign students who are to return to their native countries for medical practice. However, this national policy can be fostered through funding mechanisms other than domestic health care programs.

We would recommend that some provisions be made and added to the bill that would allow an orderly transition for those hospitals that rely on alien foreign medical graduates to meet the current patient-care needs and that some consideration be given for residents advanced in their training to allow for the completion of their programs.

The AMA believes that the studies proposed under the bill could provide useful information to help Congress and others make informed decisions concerning the complex issues related to health profession training. We would point out, however, that other groups, including HCFA and the Commonwealth Fund, are now conducting studies on cost issues related to graduate medical education. We urge that new studies build upon existing knowledge to avoid duplication of costs and resources.

In conclusion, the AMA is extremely concerned over proposals that would inappropriately reduce Medicare support for graduate medical education in order to achieve arbitrary budget targets. In fact, the impact on residency programs of recent changes in hospital reimbursement cannot be completely determined at this time. Premature action could undermine not only our graduate medical education system but the quality of our health care system as a whole. Thus, we urge the committee to proceed cautiously in its examination of the current system for financing graduate medical education.

Mr. Chairman, thank you for providing us with this opportunity to testify. I will be happy to answer any questions, and of course we welcome the opportunity to work with you on modifying the bill.

Thank you.

[The prepared statement of Dr. Louis J. Kettel follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
United States Senate

Presented by

Louis J. Kettel, M.D.

Re: S. 1158

June 3, 1985

Mr. Chairman and Members of the Committee:

My name is Louis J. Kettel, M.D., and I am Vice Chairman of the Governing Council of the American Medical Association's Section on Medical Schools. I am also Dean of the College of Medicine at the University of Arizona. Accompanying me is Harry N. Peterson, Director of AMA's Division of Legislative Activities. The AMA is pleased to have the opportunity to testify concerning the financing of graduate medical education and S. 1158, a bill that would modify the existing Medicare direct medical education pass-through.

The AMA believes strongly that the graduate medical education system in the United States is second to none and is an essential component for assuring high quality health care for the American people. In order to maintain this position, a stable environment must exist for the financing of graduate medical education.

We are very concerned over proposals to reduce federal support for graduate medical education. Such proposals, including the Administration's budget request and action by the Senate and the House in passing budget resolutions, are motivated by arbitrary budget targets without regard for the serious adverse consequences which may result from a reduction in federal assistance for graduate medical education.

Mr. Chairman, the existing system of financing graduate medical education is complex. Changes must be carefully evaluated and considered since an ill-advised change could threaten the nation's ability to train qualified physicians to meet our nation's health needs in the future.

The AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress makes substantial cuts in funding. To this end, the AMA has established an Ad Hoc Panel which will conduct a thorough study of the financing of graduate medical education.

Benefits of the Existing Financing System

Until an appropriate alternative is developed, the AMA strongly supports the current system for financing the majority of graduate medical education costs through patient care revenues from third party payors including Medicare. A key benefit of the existing system is the stable financial environment it has fostered. This predictable financial environment, in which teaching hospitals are assured that payment will be made for reasonable direct and indirect medical education costs, has been a major reason for the high quality of teaching programs available. We are concerned over proposals to restructure or dramatically reduce the funding of graduate medical education until stable alternative funding sources have been identified. Without adequate and predictable financial support, teaching hospitals would be forced to choose between two undesirable alternatives: eliminate essential teaching programs that are an integral part of the system that provides care to the sick or face large revenue shortfalls.

The present system recognizes that legitimate reasons exist for higher patient costs at teaching hospitals. Teaching hospitals generally treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients. In addition, because teaching hospitals usually contain many special care units, overall occupancy rates may be lower than those of non-teaching hospitals where beds may be available for general admission. Finally, residents place significant demands on the resources of teaching hospitals that are not found in community hospitals without teaching programs.

Administration's Budget Proposals

The Administration's fiscal year 1986 budget proposed to reduce Medicare reimbursement to teaching hospitals for the direct cost of medical education to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The Administration's budget also would cut indirect medical education payments by 50%. These proposed cuts were also included in the fiscal year 1986 budget resolution passed by the Senate. (S. Con. Res. 32)

The AMA opposes the reductions in graduate medical education funding proposed by the Administration and included in the Senate budget resolution. We are particularly concerned over the proposed 50% cut in indirect medical education costs. The impact of such a reduction would vary considerably from hospital to hospital with many inner-city and major teaching hospitals that provide substantial amounts of uncompensated or inadequately compensated care being severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact on hospitals of the recently implemented prospective payment system. This is particularly true in light of a fundamental flaw in the DRG system — the failure to reflect severity of illness and case-mix differentials.

Health Care Financing Administration Proposal

On May 21 the Health Care Financing Administration (HCFA) published a proposed rule that would limit Medicare reimbursement for direct medical education costs to the lesser of a hospital's allowable costs for its current fiscal year or the hospital's allowable costs during its cost reporting period beginning on or after October 1, 1983. The proposed rule provides that this limitation would be effective for only one year. However, in the preamble to the proposal, HCFA clearly states that for subsequent years it intends to maintain limits on Medicare payments for direct medical education costs that are "fiscally equivalent to the limits that would result from renewal of the regulations as proposed."

The AMA strongly opposes the HCFA proposal to roll back and in effect permanently freeze direct medical education costs. No specific statutory authority exists for such action. In addition, the proposal could have a serious adverse effect on the quality of patient care in teaching hospitals since residents provide substantial amounts of care to hospital inpatients. Inner-city and major teaching hospitals that provide substantial amounts of uncompensated care would be most severely affected. These institutions may be forced to eliminate teaching programs or face large revenue shortfalls.

Furthermore, HCFA's own economic analysis notes that the proposed rule would disproportionately impact on hospitals in the Mid-Atlantic and East North Central census regions. These are areas with high concentrations of teaching hospitals and are also areas that are expected to be especially affected by the continued phase-in of the DRG system.

In light of active Congressional consideration of this subject and the severe effect the proposal would have, we believe the proposed rule should be withdrawn.

S. 1158

Freeze on Direct Medical Education Costs

S. 1158 provides that during a teaching hospital's first cost accounting period beginning on or after July 1, 1985, the hospital's reimbursement for direct medical education costs could not exceed the amount the hospital was reimbursed for such costs during its last cost accounting period ending before July 1, 1985. Any salary or wage increases or any cost center shifting or reallocation implemented after May 1, 1985, would not be included in the cap amount. If a hospital's cost accounting period does not begin on July 1, 1985, the cap would be increased to reflect general increases in the costs of medical education activities (except any increases in salaries or wages) which occurred after July 1, 1985.

Such a freeze could have an adverse impact on patient care in teaching institutions. Moreover, the particular cap proposed, being set on a hospital-by-hospital basis, fails to reflect changes constantly occurring in residency positions. Some hospitals may add positions and others may decrease positions to reflect admission patterns and market forces. If any cap is to be initiated, a cap per position would appear more equitable. Nevertheless, the freeze proposed in S. 1158 is preferable to the HCFA proposal as to its level of reimbursement and limitation to one year.

The AMA recognizes the serious threat to the nation's long-term economic health posed by the huge federal budget deficits which have been projected for the foreseeable future. However, we oppose cuts in health programs that require such programs to bear a disproportionate burden of deficit reduction. We believe instead that all federal programs should accept a fair share of the burden in reducing the deficit. Thus, we would not oppose a freeze on direct medical education costs (or any other health program) for a one-year period if it is part of an across-the-board freeze on all domestic and defense spending. If Congress does not enact such a comprehensive freeze, the AMA must oppose a freeze on direct medical education costs.

Cap on Number of Years Reimbursed

The bill provides that beginning on January 1, 1986, reimbursement for direct medical education costs would be limited for each resident to the lesser of:

1) five years, or
2) the minimum number of years of formal training needed to satisfy the requirements for initial board eligibility in the specialty in which the resident is being trained, or after January 1, 1989, in the event that the required number of years in training changes, the number of years specified by the Secretary of Health and Human Services.

While we have concerns, we believe that this provision has merit in addressing graduate medical education funding. It attempts to establish a compromise between the existing open-ended reimbursement arrangement and proposals that would more severely curtail the number of residency years reimbursed by Medicare. Under this provision, primary care, general surgery and other residencies would be covered.

However, this provision would also have the effect of denying Medicare reimbursement for direct medical education costs during the last years of training for residents specializing in colon and rectal surgery, cardio-thoracic surgery, pediatric surgery, vascular surgery and neurological surgery as well as residents training in sub-specialties including those in pediatrics and internal medicine. If Medicare will not contribute its share to the full cost of training these physicians, will these programs be adequately funded? If physicians are not trained in these areas, who will provide the necessary services to Medicare beneficiaries? Will the training programs in these specialty areas be compromised in some way? Will this Medicare policy affect the policies of other payors?

We recognize the objectives sought to be achieved and appreciate the work of the sponsors in formulating this proposal. Because of the above concerns, however, we believe that this provision should not be adopted without assurances that adequate funding will remain available. Alternative sources of funding may well be forthcoming for residencies with long-term training programs. The proposal under consideration deserves careful examination.

Alien Foreign Medical Graduates

Beginning July 1, 1986, Medicare would not reimburse for the direct medical education costs of a resident who is not either a graduate of an accredited medical school in the United States or Canada or a citizen of the United States or Canada.

The AMA supports the intent of this provision of the bill. In light of the huge federal budget deficit, we believe that it is appropriate for the federal government to restrict its role under Medicare in underwriting the cost of residency training for citizens of foreign countries who have not graduated from a United States medical school. The Association has supported the national policy of making available training for foreign students who are to return to their native country for medical practice. The national policy of providing training for such alien students, however, can be fostered through mechanisms other than through domestic health care programs. It should be recognized also that there is a good percentage of alien foreign medical graduates who are on permanent residence status. Overall, we believe that savings to the Medicare program that may result from this provision may be rather modest. The U.S. immigration laws in recent years have strictly limited the number of alien foreign medical graduates who can enter the country, and alien foreign medical graduates comprise approximately 8% of the filled residency positions. We would recommend that some provision be made to allow an orderly transition for those hospitals that rely on alien foreign medical graduates to meet current patient care needs. and that some consideration be given for residents advanced in their training to allow for completion of their residency.

Studies

The bill would require that the Secretary conduct a study concerning approved educational activities relating to "nursing and other health professions" for which Medicare provides reimbursement. The Comptroller General would be required to conduct a study to determine the amount by which payments concerning items and services provided to individuals who are patients in teaching hospitals exceed the payments that would have been made with respect to such patients if they had been treated in a non-teaching setting.

The AMA supports this provision of the bill. We believe that these studies could provide useful information to help Congress and others make informed decisions concerning the complex issues related to health professions training. We would point out, however, that other groups, including HCFA and the Commonwealth Fund are now conducting studies on cost issues related to graduate medical education. We urge that new studies build upon existing knowledge to avoid duplication of costs and resources.

Conclusion

The U.S. medical education system, both graduate and undergraduate, is the benchmark against which other medical education systems in the world are judged. Preeminence in graduate medical education has been achieved by virtue of our national commitment to high quality medical care, the dedication of medical schools and teaching hospitals to high-caliber education, and the existence of stable funding mechanisms.

We are extremely concerned over proposals that would inappropriately reduce Medicare support for graduate medical education in order to achieve arbitrary budget targets. The system of financing graduate medical education is complex and changes must be carefully considered. In fact, the impact on residency programs of recent changes in hospital reimbursement cannot be completely determined at this time. Premature action could undermine not only our graduate medical education system but the quality of our health care system as a whole. Thus we urge the Committee to proceed cautiously in its examination of the current system for financing graduate medical education.

As I have indicated, the AMA appreciates the work of the sponsors of S. 1158 in addressing Medicare's role in funding graduate medical education. The AMA is itself in the process of a detailed study of graduate medical education funding. We will be pleased to keep the Committee advised of developments and to work with the Committee as it proceeds to review this subject.

Mr. Chairman, thank you for providing us with this opportunity to testify. I will be happy to answer any questions members of the Committee may have.

APPENDIX
HISTORY OF FINANCING GRADUATE MEDICAL EDUCATION

Payment for GME Under Cost-Based Reimbursement

From the inception of the Medicare program, teaching hospitals have been reimbursed on a "reasonable cost" basis for their direct medical education costs. Direct medical education costs are expenses directly related to a hospital's teaching activity. These costs include the salaries and fringe benefits of residents and the portion of teaching physicians' salaries that is attributable to educational activities.

For many years, teaching hospitals received no special payment for expenses indirectly related to the teaching of residents. Instead, provisions for reimbursement of ancillary services and the "cost-based" reimbursement system covered these costs. Then in order to prevent a disproportionate number of teaching hospitals from being adversely affected by the existing Medicare limits on reimbursement of routine hospital operating costs, HHS in 1980 modified the limits to include a resident-to-bed adjustment for the indirect costs of graduate medical education. These costs reflect the increased demands that residents place on other hospital staff and the tendency of residents to provide more services and conduct more tests. Indirect medical education costs are also used to reflect case-mix intensity. The indirect medical education adjustment was set initially at 4.7% for each 0.1 full-time equivalent (FTE) resident per bed. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) replaced the routine cost limits with limits that covered total inpatient operating costs thereby including special care unit costs under the limits. As a result, for hospital cost reporting periods beginning on October 1, 1982, the resident-to-bed adjustment was increased from 4.7% to 6.06% for each 0.1 FTE resident per bed.

Payment Under The Prospective Payment System

The Prospective Payment System (PPS), established under Title VI of the Social Security Amendments of 1983 (P.L. 98-21), retained special treatment of direct and indirect medical education costs.

Direct Medical Education Costs Under PPS

In its 1982 report to Congress entitled Hospital Prospective Payment for Medicare, HHS advocated a continuation of cost-based reimbursement for direct medical education costs. The report stated:

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives

> quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care.[1]

Congress agreed that the direct costs of medical education should not be included in the diagnosis-related group (DRG) payment. Thus under PPS, teaching hospitals are reimbursed for their direct medical education expenses on a reasonable-cost basis in addition to the DRG-based per case payment. Medicare's portion of a hospital's direct medical education costs is calculated based on generally accepted accounting principles and includes, in addition to salaries and fringe benefits, allocated overhead expenses such as administration, maintenance, and utilities.

Indirect Medical Education Costs Under PPS

The HHS report also proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. The report stated:

> The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.

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[1] U.S. Department of Health and Human Services. Hospital Prospective Payment for Medicare December 1982 PP. 47-48

> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.[2]

Congress also concurred with this recommendation and, because of analyses showing that teaching hospitals would suffer greater financial losses than non-teaching hospitals under the DRG system, P.L. 98-21 doubled the existing educational adjustment factor. In reporting the legislation, the Senate Finance Committee acknowledged that an additional payment to teaching hospitals for indirect medical education expenses is appropriate

> . . . in the light of serious doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.
>
> The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process. The committee emphasizes its view that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post graduate medical education of physicians which the Medicare program has historically recognized as worthy of support under the reimbursement system. (Emphasis added)

Under PPS the indirect medical education adjustment provides an 11.59% increase in the DRG portion of the prospective payment rate for each 0.1 FTE resident per bed. Medicare regulations define the number of a hospital's FTE residents to be the sum of the number of residents employed at least 35 hours per week, plus one-half of the number of residents who work less than 35 hours per week. The recently enacted Deficit Reduction Act (P.L. 98-369) included an amendment that permits teaching hospitals to count all residents who provide services in the hospital, regardless of whether they are employees of the hospital.

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[2] *Id.* at 48-49

Senator DURENBERGER. Thank you for your testimony.
Dr. Sledge.

STATEMENT OF CLEMENT B. SLEDGE, M.D., CHIEF, DEPARTMENT OF ORTHOPEDIC SURGERY, HARVARD MEDICAL SCHOOL, ON BEHALF OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, WASHINGTON, DC

Dr. SLEDGE. Thank you very much, Mr. Chairman, Senator Dole.

Let me first correct a misprint in my title before I get myself in trouble. I am chairman of orthopedic surgery at Brigham and Women's Hospital and Harvard Medical School in Boston, and president of the American Academy of Orthopaedic Surgeons. I greatly appreciate the opportunity to testify before your committee today on this extremely important bill that affects all of us, not only providers but consumers of medical care in this country.

My comments will represent the thoughts of one who practices in a subspecialty of surgery, and therefore I may have a slightly different pitch from some of those you have heard before.

I think it is useful to examine the purpose of the proposed legislation, at least from my point of view to examine it. Is it to save Medicare money? The costs of medical education will continue; they will be shifted somewhere else, presumably. Is it to decrease medical manpower? That seems to reverse a trend that several of the deans who appeared on the previous panel addressed, on the need to continue the production of high-quality manpower. Or is it to redistribute medical manpower away from certain areas into other areas? And here we heard also one of the previous panelists discuss the difficulties in defining what "primary care" is.

We believe that one should continue to support medical training through initial board certification. The development of the board concept has come about very slowly and very carefully over a number of years and has resulted in a quality of training in this country that has made it the desire and envy of every other nation. It has not happened through haphazard happenstance; it has been very carefully thought out. As the knowledge base increases, the length of time to achieve a significant portion of that knowledge base has also increased.

Orthopedic surgery is a subspecialty of surgery, but you should not forget that it does produce a substantial portion of primary care. Fifteen percent of visits to an orthopedic surgeon's office are in the area of primary care. If you sprain your ankle running through Rock Creek Park, I suspect you would consider the orthopedic surgeon who took care of you a primary-care physician. If you wake up with low back pain, I think you would also consider him your primary care physician.

Because of that, I think it is very difficult and dangerous to try to categorize professions as primary or subspecialty.

The training of a surgery subspecialist must, of necessity, be quite lengthy. The subspecialist must first master the basic rudiments of his parent specialty. One or two years of training in general surgery is generally considered advisable for training in a surgical subspecialty. Following that, 3½ or 4 years of specific training in the basic sciences of a surgical subspecialty and the clinical practice of that specialty are felt to be necessary.

Remember that subspecialties such as orthopedic surgery deal with a tremendous range of illness, from arthritis to injuries to motor vehicle accidents to congenital maldevelopments. It covers every age span from the newborn to a tremendous percentage of patients in the geriatric range. It requires not only training in surgery but training in the aspects of rehabilitation that are so necessary to return patients to full and complete function.

Indeed, this knowledge base is so extensive that, in addition to 5 years of post-M.D. training, the American Academy of Orthopaedic Surgeons sponsors over 100 graduate medical education courses each year to enable practitioners of orthopedic surgery to keep up with this rapidly expanding knowledge base.

We believe it is useful to ask yourself why it is that so many foreign medical graduates seek training in this country. And, perhaps more importantly, why it is that we are inundated not just with foreign medical graduates coming here for training but with foreign nationals who seek to come here to have their medical care? It is because we produce the highest quality medical care system in the world.

I would like to close by paraphrasing, with your indulgence, the old statement that "if it ain't broke, don't fix it"—certainly don't fix it until you are certain that you can make it better, and certainly not just to shift dollars from the Medicare budget. It is a complex educational mix that has evolved slowly. We heartily endorse your efforts to control costs and appreciate the opportunity to testify today, and we look forward to working with you as this bill is developed.

Thank you very much, sir.

Senator DURENBERGER. Thank you very much, Dr. Sledge.

Let's see, who is next? Dr. Ruberg.

[Dr. Sledge's written testimony follows:]

STATEMENT OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, PRESENTED BY CLEMENT B. SLEDGE, M.D., JUNE 3, 1985

Mr. Chairman and members of the Committee, I am Clement B. Sledge, M.D., Chairman of the Department of Orthopaedic Surgery at Harvard Medical School in Boston, Massachusetts and the President of the Academy of Orthopaedic Surgeons.

I am grateful for this opportunity to testify today on S. 1158 relating to Medicare payments for direct costs of approved education activities. It is clear that the authors are sensitive to the complexities of GME, yet responsibly concerned with rising Medicare costs. As noted in the bill, the nation's graduate medical education system is a priceless national resource. It is to the health care system the equivalent of industry's investment in research and development and in capital facilities and technology. It has yielded the most knowledgeable and effective medical work force in the world.

All programs in graduate medical education, including orthopaedic surgery, have for some time received part of their financial support from hospital patient revenue. A portion of this support was administered by HCFA through the Medicare Program, while other parts were paid by private insurers and other sources of revenue not directly related to patient care reimbursement through the hospitals.

Both government and private insurers are now seeking ways to reduce overall expenditures on health care and are considering educational costs as a potential source for reduction of expenses. While reducing the share Medicare might pay for GME may reduce overall Medicare expenditures by a fraction of a percent, the costs will still remain. Teaching hospitals provide a resource for physician training, innovative new research in patient care and in many cases the only available source for the care of indigent patients and complex medical problems. To continue our current level of medical care for the public, it is essential to society that these hospitals be maintained.

We recognize that medical education, both undergraduate and graduate, must assume its fair share of cost savings. We are currently promoting efforts to become more efficient through cost containment teaching programs, increased internal supervision of expenditures, and other methodologies that will reduce the cost to the provider for the care in teaching hospitals.

Even within the medical community, consensus does not exist on the best approach or on the consequences of various alternatives. Studies are currently under way by HHS, the Commonwealth Fund Task Force on Academic Medical

Centers, the Association of American Medical Colleges, American Medical Association, and American Hospital Association. Until these studies have been completed, and particularly studies on the significant effects of prospective pricing on teaching hospitals, I believe that the level of GME support should continue to recognize the minimal education necessary for certification by a specialty board.

The cost to hospitals for GME is presently disproportional. Fifty percent of residency training occurs in two percent of the nation's 5,900 communnity general hospitals. This two percent represents the majority of the nation's teaching hospitals. They are a national, as well as a state and local resource. The remaining residents receive training in 1,100 other hospitals. Without the differential subsidy from public and private third party payers, the teaching hospitals could not provide patient care to the complex case mix which is part of the teaching hospital environment and one of their major contributions to the public. While the cost of care in teaching hospitals may be higher than in the community general hospital, several benefits accrue to the general public: well trained physician specialists in all disciplines, biomedical research, training of allied health professionals and care of complex problems and critically ill patient. These combinations have provided major advances and innovation in health care within this country.

Several possible alternatives exist relative to funding for GME that would reduce the current cost. First, one might reduce the direct and indirect payment per resident; secondly, reduce the number of residents or thirdly, limit the number of years that a resident might be compensated. Any drastic change in the current direct and indirect payment level will likely have a great effect on the ability of teaching hospitals to deliver services as regional centers of excellence for critically ill patients. Reducing the number of residents implies a direction for controlling the number of physicians available to the public. Extreme caution must be exercised in abandoning the free enterprise driven GME system, however imperfect it might be. There are still many areas in the U.S. that are inadequately served by physician specialists and it seems most likely that supply and demand, as well as cost considerations in teaching hospitals, will control the number of physicians in training over the years to come.

Actions to limit the number of years of GME to be financed must take into account the 60 years of advances in the science of medicine and the accrual of information that have created the specialty areas within the U.S. In orthopaedic surgery, our criteria for a minimal education experience of five years following medical school education have derived from years of experience in the complexities of the illnesses with which our specialty deals. These criteria have been accepted by the American Board of Medical Specialties, who have recognized the education needs proposed by the Residency Review Committee and our certifying board.

In summary, I wish to make the followng three points concerning S. 1158:

1. From our perspective, we believe the proposed limit on the financing of GME to the number of years required for initial board certification is a resonable approach to effecting cost savings to the Medicare program. In the next three years, orthopaedic surgery will be pleased to participate in a careful examination of the content and duration of residency training programs. An important assumption inherent in our examination is that specialty training periods must provide sufficient time and exposure to clinical material in order to assure the production of a competent orthopaedist.

2. The proposed 1-year freeze on direct cost payments could cause disruption in many of the nation's

teaching hospitals. The combined effects of the freeze, in addition to the uncertain effects of PPS on teaching hospitals and the possibility of further downward adjustment in the reimbursement for the indirect cost of GME, may have a grave effect on the ability of teaching hospitals to train physicians and to meet the needs of their communities.

3. We understand the desire to limit Medicare funding to graduates of ACME accredited schools. We are concerned, however, that unless alternative sources of support are developed, there may be two unintended results:

   * the U.S. may loose its pre-eminent role as the medical educator for the world;

   * the U.S. may lose the future contributions of foreign trained physicians, many of whom have in the past and would in the future make an irreplaceable contribution to science and clinical care.

During the past 20 years, and particulary the past decade, there has been a quiet revolution occurring within our specialty. We have not been on the front page of newspapers, but it has been happening. Quietly through enlightened research, enriched clinical skills, improving technology, and state-of-the-art teaching our specialty has steadily advanced. Breakthroughs have occurred in joint replacement procedures, diagnostic and surgical treatment of injuries, use of laser technology and microsurgical techniques, bone implants, tumor surgery, rehabilitation modalities, arthritis treatment, and prevention of osteoporosis. Important epidemiology studies have been undertaken to achieve a better understanding of musculoskeletal disorders. All of these advances require a well trained orthopaedic specialist in order to generate and translate these findings into quality patient care.

This Academy is prepared to join with all interested parties in working with you to address the important issue of financing graduate medical education. Precipitous action must be avoided, for the effects can be extremely harmful. We believe the common ground can and will be found through our joint effort.

STATEMENT OF ROBERT L. RUBERG, M.D., ASSOCIATE PROFESSOR OF SURGERY, OHIO STATE UNIVERSITY COLLEGE OF MEDICINE, COLUMBUS, OH, ON BEHALF OF THE AMERICAN SOCIETY OF PLASTIC & RECONSTRUCTIVE SURGEONS, WASHINGTON, DC

Dr. RUBERG. Mr. Chairman, the American Society of Plastic & Reconstructive Surgeons appreciates the opportunity to appear before you today. I am Robert L. Ruberg, M.D., associate professor of surgery at the Ohio State University College of Medicine in Columbus. I practice my specialty, plastic surgery, at the university teaching hospital and very much appreciate the opportunity to express our society's views regarding S. 1158.

We substantially support the views of the American College of Surgeons, to which we belong and which you will be hearing from in a few moments; however, we have special concern about the future of our plastic surgery residencies, and we wish to bring those concerns to your attention today.

The discipline of plastic and reconstructive surgery plays a critical role in comprehensive health care. Although the lay public often views the plastic surgeon exclusively as a cosmetic surgeon, the medical profession recognizes plastic and reconstructive surgeons for their expertise in a variety of essential areas.

Plastic surgery has traditionally been in the forefront of surgical care, developing new techniques for dealing with problems not solved by traditional methods. Many of these methods are later adopted by other practitioners such as orthopedic surgeons, general surgeons, urologists, and so forth.

In recent years the innovative techniques of microsurgical free tissue transfer, reattachment of amputated parts, craniofacial surgery, musculocutaneous flaps, all have been developed principally through the efforts of plastic and reconstructive surgeons. So, in our view, plastic surgeons have clearly been prolific developers of innovative surgical methods.

In order for us to continue providing this kind of intensity and diversity of medical care, we must continue to provide a thorough and comprehensive training program for our residents. In our residencies, we work to develop surgical skills and reasoning beyond that of the general surgical practitioner; therefore, our training programs are of necessity long and arduous.

The current requirement of the American Board of Plastic Surgery, as of April 1985, is a minimum of 6 years of surgical training beyond medical school. Each resident must have a minimum of 3 years of general surgery training; some take more and may even achieve general surgery board eligibility prior to starting their residency in plastic surgery. Thus, for all of our residents, some or all of their plastic surgery training period would fall outside the 5-year limit.

From this description, it should be clear that that portion of S. 1158 which limits support to either 5 years of residency or initial board eligibility will have a detrimental effect on plastic surgery training programs and on comprehensive medical care.

Now, our objection to such limitations does not imply that we favor unlimited funding for plastic surgery residents. We take the position that funding of plastic surgery is just as important as funding of family medicine, internal medicine, and pediatrics; but we readily acknowledge that the number of plastic surgeons who should be trained is considerably smaller than the number of family physicians, internists, et cetera. So we accept the idea of differential funding to promote selected specialties, but we oppose the notion that certain specialty training programs, in our instance plastic surgery, should be substantially unfunded.

The ASPRS would support a responsible plan, one which would channel the majority of graduate education funds into the primary care fields, provided that funding for existing plastic surgery training is maintained.

How would we do that? We support S. 1158, except that we propose funding for the minimum number of years needed for board eligibility in each discipline. For most specialties this would mean no change from the current limitations in S. 1158, calling for a maximum of 5 years. For plastic surgery, however, this would mean funding for 6 years of training, since that is our board's minimum.

Also, because the total number of residents in our specialty—approximately 400—is extremely small compared to virtually every other discipline, this proposal would result in only a very modest increase in expenditure over the 5-year maximum plan, yet it would preserve our discipline and recognize its essentiality.

The ASPRS feels that this modification in S. 1158 to fund training through minimum board eligibility for each specialty would provide a mechanism for controlling graduate medical education costs and channeling funds into underserved specialties while still preserving the training of adequate numbers in all the essential medical disciplines.

Mr. Chairman, I thank you for your time, and I would be happy to respond to any questions.

Senator **Durenberger**. Thank you, Dr. Ruberg.

Dr. Sheldon.

[Dr. Ruberg's written testimony follows:]

TESTIMONY OF ROBERT L. RUBERG, M.D., ASSOCIATE PROFESSOR OF SURGERY, OHIO STATE UNIVERSITY COLLEGE OF MEDICINE, ON BEHALF OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

Mr. Chairman and Members of the Committee: The American Society of Plastic and Reconstructive Surgeons, Inc., appreciates the opportunity to testify before you today. I am Robert L. Ruberg, M.D., Associate Professor of Surgery at the Ohio State University College of Medicine in Columbus, Ohio. I practice my specialty, plastic surgery, at a university teaching hospital and very much appreciate the opportunity to express ASPRS' views regarding recent proposals to alter the system for funding graduate medical education, particularly S. 1158. Changes in our current system can have a profoundly adverse effect on the conduct of our residency programs in the specialty of Plastic and Reconstructive Surgery. It is imperative, therefore, that we step forward to acquaint you with the role of our specialty in the provision of comprehensive medical care, to provide our views on the potential effects of altering the current funding mechanisms, and to offer our suggestions for a more equitable and responsible funding system. We support substantially the views of the American College of Surgeons, to which we belong and who appear before you today. Additionally, though, we have a special concern about the future of Plastic Surgery residencies and wish to highlight our particular situation today.

ASPRS recognizes the need for a more accountable and cost-conscious system for funding graduate medical education. The existing mechanism provides satisfactory levels of funding but has no means for control of excessively long training programs, prevention of overproduction of specialists and underproduction of primary care physicians and limitation of extravagant use of educational funds. ASPRS favors changes in the funding of graduate medical education which will facilitate these objectives yet will also preserve necessary training in _all_ _essential_ _medical_ _disciplines_.

I. THE ROLE OF PLASTIC AND RECONSTRUCTIVE SURGERY IN COMPREHENSIVE HEALTH CARE: The discipline of Plastic and Reconstructive Surgery plays a critical role in comprehensive health care. Although the lay public often views the plastic surgeon exclusively as a cosmetic surgeon (performing face lifts, "nose jobs" and the like), the medical profession recognizes plastic and reconstructive surgeons for their expertise in a variety of essential areas. Cosmetic or "aesthetic" surgery forms only a portion of our practice. Plastic Surgery includes acute and reconstructive care of burn injuries, management of injuries of the face and hand, treatment and reconstruction of head and neck tumors, surgical therapy of skin tumors and disorders, management of wound healing problems, treatment of congenital anomalies of the head and neck (including cleft lip and palate) and of the extremities and elsewhere on the body, rehabilitative surgery of the spinal cord injured patient (bedsores and upper extremity problems), and a large area we would call "general reconstruction." Plastic Surgery has traditionally been in the forefront of surgical care, developing new techniques for dealing with problems not solved by traditional methods. Many of these methods are later adopted by other surgical practitioners such as orthopedic surgeons, general surgeons, urologists, etc. In recent years the innovative techniques of microsurgical free tissue transfer and reattachment of amputated parts, craniofacial surgery and musculocutaneous flaps have been developed principally through the efforts of plastic and reconstructive surgeons. As these techniques have moved into more general use by other surgical disciplines, plastic surgeons have gone on to the refinement of still newer and more advanced techniques such as tissue expansion. In our view plastic surgeons have clearly been prolific developers of innovative surgical methods.

In addition to the contributions to the advancement of surgical methods, plastic surgeons, through residency training programs and the charitable efforts of our certified practitioners, have provided essential care to indigent patients with conditions such as cleft lip and palate, burns, bedsores, traumatic injuries, and other difficult problems. Although other disciplines may partly overlap our efforts in some of these cases, the majority of care for most of these critical areas of medical practice is provided by plastic surgeons.

II. IMPACT OF CHANGES IN FUNDING OF GRADUATE MEDICAL EDUCATION ON PLASTIC SURGERY TRAINING: In order for plastic surgeons to continue providing this kind of intensity and diversity of medical care, we must continue to provide a thorough and comprehensive training program for our residents. In our residencies we work to develop surgical skills and reasoning beyond that of the general surgical practitioner. Therefore, our training programs are of necessity long and arduous.

The current requirement of the American Board of Plastic Surgery (revised in April 1985) is a minimum of six years of surgical training beyond medical school. Each resident must have a minimum of three years of general surgical training; however, many of our residents actually complete general surgery training (i.e., five or more years) prior to entering the Plastic Surgery residency. If a resident enters Plastic Surgery training after only three years of general surgery training, he or she will have to complete three years of Plastic Surgery training (for a total of six years). Those who enter with four or more years are nonetheless required to take two years of Plastic Surgery residency. Thus all of our future residents must have at least six years of residency, and many may have achieved board eligibility in general surgery and a total of seven or more years of residency. The nature and length of a Plastic Surgery residency is dictated by various factors, notably the different requirements of teaching versus practice and among various types of practices.

From this description, it should be clear that any proposals for funding graduate medical education which limit support to either five years of residency (such as S.1158), or other proposals to limit funding to "initial board eligibility" will have a major impact on Plastic Surgery training programs. Under a five-year limit, even if a resident has taken the minimum training for board eligibility in Plastic Surgery, the last (i.e., sixth) year of residency would be "unfunded." If funding is terminated at the fifth year, those residents who complete a five-year general surgery program prior to entering Plastic Surgery residency would be ineligible for funding for any of their Plastic Surgery-specific training. And, under an approach limiting funding to "initial board eligibility", residents who complete their training first with five years of general surgery (therefore becoming board eligible for general surgery) would be ineligible for funding for any of the Plastic Surgery residency.

Even more confusion may result in those residencies in which some residents enter training after three years of general surgery, others after four, and others after five--all within the same training program. Under a five year limit some of the residents in such a program would be funded for part of their residency, others not at all, and the number of funded residents could change from year to year depending on the amount of general surgery training of the entering residents.

We see obvious problems with the system outlined above. We consider Plastic Surgery to be an essential discipline. Therefore, it is our view that a limitation of graduate medical education funding to five years or the alternative limitation to "initial board eligibility" would be detrimental to our discipline.

Our objections to such limitation should not imply that we favor unlimited funding for Plastic Surgery residencies. We take the position that funding of Plastic Surgery is just as important as funding of family medicine, internal medicine, pediatrics, etc.--but we readily acknowledge that the NUMBER of plastic surgeons who must be trained is considerably smaller than the number of family physicians, internists, pediatricians, etc. whose training should be funded. Any proposal which cuts off funding would be detrimental to modern comprehensive medical care. Thus we accept the idea of differential funding to promote selected specialties, but we oppose the notion that certain specialty training programs (notably Plastic Surgery) should be substantially unfunded.

A responsible proposal for controlling and realigning the funding of graduate medical education would be one which acknowledges the need for support for all the essential medical disciplines (including Plastic Surgery), yet recognizes that the amount of funding needed to train adequate numbers of practitioners in each of the medical disciplines may be radically different. The ASPRS would support a plan which would channel the majority of graduate education funds into the primary care fields, provided that funding for existing Plastic Surgery training is maintained.

III. AN ALTERNATE PLAN FOR "RESPONSIBLE" FUNDING OF GRADUATE MEDICAL EDUCATION: In order to maintain adequate numbers of all the essential medical disciplines, yet control unlimited spending for unlimited periods of residency, we propose funding for only the minimum number of years needed for "board eligibility" in each discipline. For most specialties this would mean no change from the current limitations in S. 1158 calling for a maximum of five years. For Plastic Surgery, however, this would mean funding for six years of training, since this is the Board's minimum. Because the total number of residents in our specialty (approximately 400) is extremely small compared to virtually every other discipline, this proposal would result in only a modest increase in expenditure over the "five year maximum" plan, yet it would preserve our discipline and recognize its essentiality. By limiting funding to only the minimum years for board eligibility, we would eliminate expenditure for years of training which are not essential--and thus reduce and more effectively control the total cost of graduate medical education. The ASPRS feels that this modification in S. 1158 to fund training through minimum board eligibility for each specialty would provide a mechanism for controlling graduate medical education costs and channeling funds into underserved specialties while still preserving the training of adequate numbers in all the essential medical disciplines.

Mr. Chairman, thank you for your time. I would be pleased to respond to your questions.

STATEMENT OF GEORGE SHELDON, M.D., CHAIRMAN, DEPARTMENT OF SURGERY, UNIVERSITY OF NORTH CAROLINA; REGENT, AMERICAN COLLEGE OF SURGEONS, CHAPEL HILL, NC

Dr. **Sheldon**. Mr. Chairman and members of the subcommittee, I am George F. Sheldon. I am professor and chairman of the department of surgery at the University of North Carolina. I am speaking on behalf of the American College of Surgeons, of which I serve on the board of regents. We are grateful for the opportunity to comment on this proposed legislation.

The American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery. Its membership is composed of 55,000 members throughout the United States and abroad. The college's commitment to the quality of surgical care and medical care extends to 1918 when it established the Hospital Accreditation Program that has since evolved into the Joint Commission on Accreditation of Hospitals.

The American College of Surgeons supports your proposed legislation, because we recognize the need for Congress and the private sector of the health care system to confront the Federal budget deficit and the striking rise in costs of health care. We support such action as part of a general freeze on payment for Medicare activities, but we see no fairness in singling out graduate medical education for a solitary restriction.

Physicians in training are a priceless national resource that provide valuable care to the aged and socially deprived whose surgical diseases are often quite challenging and which account for a large part of the heavy clinical load which is assumed by urban teaching hospitals.

We consider the proposal acceptable to fund after July 1, 1986, those costs for years of training which do not exceed the lesser of 5 years or the minimum number of years of formal training for initial board eligibility or certification. We suggest, however, that alternatives be sought to fund those specialties that require more than 5 years of training, such as colorectal surgery, cardiothoracic surgery, neurosurgery, pediatric surgery, plastic surgery, and vascular surgery. The life-saving advances which have come from these specialties are needed. We recognize the need for extra years because of the increased cognitive knowledge, analytic reasoning, and technical skills which must be imparted during these periods of time, and these particular specialties are now an expected and essential part of everyday medical practice.

Now, several features of graduate medical education in surgery are different from other specialties. For example, it takes longer to become a surgeon than it does to graduate from medical school.

In addition, in the concern we have about numbers of physicians and surgeons, we would like to point out that a limitation already exists on the number of surgeons educated in the United States through existing mechanisms. Less than 3,000 surgeons in nine specialty fields will complete their training as of this summer. The number of surgeons certified by their respective specialty boards has declined from 4,200 in 1981 to 3,584 in 1983.

In addition, the number of training programs in general surgery have diminished from 729 in 1959 to 320 in 1983.

Now, we would like to also point out that nothing is more expensive both in fiscal as well as in human terms than surgery performed by untrained or minimally trained individuals. And the extra years of training in surgical specialties are devoted not only to technique but in teaching our trainees when not to operate as well as when to operate.

We agree that Medicare funding should not be used for the training of graduates of schools other than those approved by the liaison committee on medical education. However, the educational facilities of the United States should continue to be made available to medical graduates from other countries so that the United States may continue its world leadership role in medical education. We think this is right, proper, along with our tradition, and it is good foreign policy.

The American College of Surgeons appreciates the opportunity to present our views on this issue, which of course is of considerable interest to the surgical profession. Our views have been accepted in principle by the following surgical specialty societies: The American Academy of Otolaryngology, the American Association for Thoracic Surgery, the American Pediatric Surgical Association, the American Society of Colon and Rectal Surgeons, the American Urological Association, the International Society for Cardiovascular Surgery, and the Society for Vascular Surgery, and others.

We thank you very much for the privilege of being here.

Senator **Durenberger**. Thank you, Dr. Sheldon.

Dr. Hook?

[Dr. Sheldon's written testimony follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health
Committee on Finance
U.S. Senate

Presented by

George F. Sheldon, M.D., F.A.C.S.

RE: S. 1158 - To Amend Title XVIII of the Social Security
Act with Respect to Medicare Payments for Direct Costs
of Approved Educational Activities

June 3, 1985

Mr. Chairman and Members of the Subcommittee:

My name is George F. Sheldon, M.D., Chairman of the Department of Surgery at the University of North Carolina at Chapel Hill, North Carolina and a member of the Board of Regents of the American College of Surgeons. I am grateful for the opportunity to comment on the bill (S. 1158) to amend Title XVIII of the Social Security Act with respect to Medicare payments for direct costs of approved educational activities.

The American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of a high quality of care for the surgical patient. For more than 70 years the College has provided educational programs for a group of more than 55,000 Fellows and candidates as well as for other surgeons in this country and throughout the world. The College establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

In 1918 it established a hospital accreditation program that became the Joint Commission on Accreditation of Hospitals in 1953. We believe that federal support of medical education and research has been largely responsible for the preeminence of American medicine and surgery.

The American College of Surgeons supports the proposed legislation, because we recognize the need for the Congress and the private sector of the health care system to confront the federal budget deficit and the striking rise in costs of health care. The bill proposes that a freeze be enacted for all Medicare direct cost payments of approved educational activities for fiscal year 1986. We support such action as part of a general freeze on payment for Medicare activities but see no fairness in singling out graduate medical education for solitary restriction. It is in society's best interest to maintain the highest quality of graduate medical education in order not to lose the advantages that have been essential in making our system of education combined with patient care the envy of the world.

Physicians in training constitute a priceless national resource that provides especially valuable care for the aged and socially deprived whose surgical requirements are often extremely demanding. Moreover these patients account to a significant degree for the heavy load of clinical care that is placed on urban teaching hospitals. For these reasons we maintain that it is critically important for Medicare patients and for all of society to continue to benefit from this national resource.

We consider acceptable the proposal to fund after July 1, 1986 those costs for years of training which do not exceed the lesser of five years or the minimal number of years of formal training for initial board eligibility for certification. We suggest, however, that alternatives be sought for funding those specialties that require more than five years of training, such as colorectal surgery, cardiothoracic surgery, neurosurgery, pediatric surgery, plastic surgery and vascular surgery. The life saving advances in these disciplines, brought about by a broad biologic background, cognitive knowledge and analytical reasoning combined into seasoned surgical judgment and high technical skills must be preserved and extended for present citizens and for future generations. The American College of Surgeons is eager to cooperate in devising solutions for the preservation of these vital specialties, many of which have advanced the frontiers of knowledge by way of diagnostic and treatment methods that are now essential parts of everyday medical care. As the Congress reviews the steps essential to bringing our Medicare system into more reasonable fiscal limits, we trust that this urgent financial crisis will not obscure the need to plan for the long range care of all of our citizens by way of essential surgical advances.

Several features of graduate medical education are different for surgery than for other medical specialties. For example, a limitation on the number of surgeons educated each year already exists. Less than 3,000 surgeons in nine specialty fields complete training annually. The number of surgeons certified by their respective specialty boards declined from 4,200 in 1981 to 3,584 in 1983. Moreover, the number of training programs have decreased from a high of 729 in 1959 to 320 in 1983. Nothing is more potentially expensive than surgery performed by untrained personnel such as those with minimal or inadequate surgical education. We believe the number of genuine surgeons produced annually is a fragile number and are uncertain whether fewer surgeons could meet the nation's needs. Let me emphasize that the number of individuals with inadequate credentials who are carrying out surgical operations should not be used as a measure of the system required to produce genuine, skilled surgeons capable of deciding when not to operate as well as to carry out the procedures safely and skillfully when their necessity is assured.

We agree that Medicare funding should not be used for the training of graduates from schools other than those approved by the Liaison Committee on Medical Education. However, the educational facilities of the United States should continue to be made available to medical graduates from other countries so that the United States may continue its world leadership role in medical education.

The American College of Surgeons appreciates the opportunity to present our views on this issue, which is of considerable interest to the surgical profession. Our views have been accepted in principle by the following surgical specialty societies:

American Academy of Otolaryngology -- Head and Neck Surgery, Inc.
American Association for Thoracic Surgery
American Pediatric Surgical Association
American Society of Colon and Rectal Surgeons
American Urological Association
International Society for Cardiovascular Surgery
Society for Vascular Surgery

I would be happy to respond to your questions.

Graduate Medical Education Factsheet

Residency Training

- In 1983-84, there were 127 U.S. medical schools with 67,443 medical students.
- Graduate medical education occurs in 1,225 of the nation's 6,000 hospitals with 125 of these hospitals providing 50 percent of the nation's residency training.
- There are currently 4,749 accredited programs. These accredited programs "offered" 76,849 total positions, of which 1,724 were unfilled. Of the 19,817 post-graduate year one positions "offered," 278 were unfilled.
- There were 75,125 residents on duty in accredited programs.

  60,044 U.S. LCME graduates; 406 Canadian LCME graduates; 1,150 Osteopathic graduates and 13,525 FMGs. Of the foreign medical graduates, 55 percent were U.S. citizens and 45 percent were non-U.S. citizens.

- 55 percent of residency training takes place in eight states:

State	Number of Programs	Percent of Programs	Percent of Residents
New York	614	12.8	14.6
California	476	9.9	9.6
Pennsylvania	329	6.8	6.4
Illinois	275	5.7	5.6
Texas	266	5.5	5.8
Ohio	260	5.4	5.1
Michigan	209	4.3	4.0
Massachusetts	188	3.9	4.0

- In 1970-71, the surgical specialties comprised 39.8 percent of the total residency positions filled for all years, compared to 26.3 percent for the primary care specialties. By 1983-84, the percentage of surgical positions filled for all years had decreased to 28.1 percent and primary care had increased to 42.8 percent.

Source:

Anne E. Crowley, Ph.D., Director of the AMA Office of Educational Directories.

The National Resident Matching Program

- 1.14 positions/applicant; 70 percent of available positions filled in Family Practice, Pediatrics, Psychiatry, Pathology; 70 to 80 percent in Internal Medicine; 80 to 90 percent in the Surgical Specialties, Ob-Gyn, Radiology; and 90 percent in Emergency Medicine and Anesthesia.

- The rates of 1.14 position/applicant in the NRMP reveals an evolving phenomenon whereby the pool of graduates may lack GME positions as has occurred in other countries including Canada.

- The percentage (41.5 percent) of U.S. medical school seniors whose first choice was a surgical specialty failed to match in the NRMP in 1984.

Source:

Graettinger-CMSS-March, 1985

Applicable Comments on Residency Training

- The 335 member institutions of the AAMC's Council of Teaching Hospitals, which comprises 5.8 percent of the nation's community hospitals, incurred 31.5 percent of the bad debts and rendered 51.1 percent of the charity care in 1982. These 335 hospitals accounted for 27.4 percent of the inpatient expenditures of all non-federal short term community hospitals.

- The Residency Review Committees for specialties other than the surgical specialties do not specify the number of residency positions accredited.

- 83 percent of residency stipends are paid from patient revenues and general operating appropriations of hospitals, 6 percent from state appropriations, and 11 percent from other sources.

STATEMENT OF EDWARD W. HOOK, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, PHILADELPHIA, PA

Dr. Hook. Thank you, Senator Durenberger.

I speak today on behalf of the American College of Physicians. I am president of the college, an organization which represents over 60,000 internists, including general internists, subspecialists, and physicians in training.

During the brief time allotted this morning we wish to emphasize certain specific points which are relative to Senate bill 1158.

First, we support the major provision of the bill which would limit the length of the training period that will be supported by Medicare payments. However, we are sincerely concerned that the period of support outlined in the legislation—namely, the lesser of time required for initial board eligibility or 5 years—that this specified period of support may have implications beyond those envisioned by the sponsors.

Whereas we are totally supportive of the concepts inherent in the bill to emphasize and ensure training of residents in primary care disciplines, we are concerned that the wording of this specific provision may eliminate support for important and even critical medical subspecialties and areas of training, for example, in geriatrics or oncology, areas that are vitally important to the mission of the Medicare Program and to the anticipated future health care needs of the Nation.

The training of medical subspecialists requires a period of at least 5 years just as in orthopedic surgery or urology—for the medical subspecialists, an initial 3 years of training in general internal medicine, plus at least 2 additional years of subspecialty training. These medical subspecialties would be excluded from support under the provisions of S. 1158, because the boards which set the standards for these subspecialties and which certify competence in these areas are secondary to the primary board, the American Board of Internal Medicine. We wonder if it was in fact the intent of the sponsors to exclude these essential practitioners, in view of the sponsors' willingness to support, for a 5-year period, trainees in other disciplines.

We strongly support those provisions of the legislation that would end Medicare support for the training of alien foreign medical graduates. We do believe, however, that the issue of training of alien foreign medical graduates requires further discussion. We feel that we must carefully examine the appropriate role of this Nation in sharing its resources and expertise in medical education with other nations. If the United States is to maintain its commitment to international health for humanitarian reasons or as a matter of foreign policy, then training opportunities for alien foreign medical graduates who will return to practice in their own countries must be provided. It does seem that other mechanisms might be found outside of the Medicare Program for continuing this international role in which, in the past, we have been leaders.

We disagree with those provisions of the bill that permit the continuation of Medicare support for the graduate training of U.S. citizens who have received their medical education in institutions which are outside of the United States and Canada and which are unaccredited by the Liaison Committee on Medical Education. At a time when we are adopting national and State policies that will curtail the projected surplus of physicians, including reducing the class size of a number of U.S. medical schools, and at a time when we are emphasizing the importance of maintaining standards, it would appear to be contradictory to continue to provide financial support through Medicare for the advanced education of individuals who are graduates of unaccredited medical schools outside of the United States.

Finally, we support the concept of a freeze for 1 year on Medicare payments for direct medical education as a means of achieving short-term budgetary savings and to provide time for hospitals to plan for change.

Mr. Chairman, that concludes my comments. I wish to express our apprciation for the efforts made to date by the sponsors of the proposal, and your willingness to hear us today. We at the American College of Physicians stand ready to aid you, to work with you, in whatever way might be helpful as these matters are further discussed.

Thank you.

Senator DURENBERGER. Thank you, Dr. Hook.

[Dr. Hook's written testimony follows:]

STATEMENT
OF
THE AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

June 3, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Edward W. Hook, M.D., F.A.C.P., Henry B. Mulholland Professor and Chairman of the Department of Medicine at the University of Virginia School of Medicine. I speak today on behalf of the American College of Physicians, of which I am President.

The College represents over 60,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Approximately one-third of the ACP membership are Fellows of the College (FACP), a designation based upon their having met standards of scholarship and contribution to the science and practice of medicine beyond their eligibility for board certification in internal medicine.

Founded in 1915 to uphold high standards in medical education, medical practice, and medical research, the College was for many years primarily educational and honorific in nature. Increasingly, however, as payment policies have come to affect medical practice (and more recently, medical education and medical research), the College has become extensively involved, at both conceptual and practical levels, in the issues raised by payment policies. Just as budget policy is linked with health policy, payment policy is linked with medical practice and medical education. And just as this committee is rightly concerned that budget policy not inappropriately affect good health policy, the College is concerned that payment policies not inappropriately affect medical education.

The College's statement today outlines the principles that we believe should be followed in any discussion of payment policies affecting medical education. It addresses certain of the provisions of S. 1158 that would change the present mechanism of Medicare payment for financing graduate medical education.

The first two principles are fundamental: (1) graduate medical education is linked with patient care and is practically inseparable from patient care; and (2) graduate medical education and the environment in which it takes place -- generally, the teaching hospital -- serve the public good. The positions that follow maintain that continuation of some public financial support of GME is necessary, and that private support through payments for patient care services is also justified.

The College believes that the complexity of modern medical care necessitates that all new physicians complete residency training in an accredited GME training program. The issue of financing GME must be addressed in a comprehensive national health manpower policy in which the supply and specialty distribution of physicians are coordinated with national, state, and local health manpower needs. Financing of GME must also be considered in formulating public policy regarding physician reimbursement. Opportunities should continue to exist for the training of limited numbers of foreign medical graduates (FMGs) who will return to their country of origin upon completion of training.

PRINCIPLES FOR FINANCING GRADUATE MEDICAL EDUCATION:

1. Graduate medical education is fundamentally linked with patient care and for practical purposes is inseparable from patient care. Therefore, patient care revenues should continue to be an appropriate source of funding for GME.

Graduate Medical Education (GME) is principally comprised of two components: expansion of the knowledge base gained in undergraduate medical education and development of the clinical experience base started in medical school. In large part, education in these two components is gained through observation, performance, and the teaching of others. The first two of these activities represent the medical service itself; the third represents a refinement of the service. The fact that all three take place in the educational setting, under the supervision of clinical faculty, endow them all with an educational aspect in addition to their inherent patient care aspect. Thus, because the setting of the service involves both patient care and education, the educational and care components are not readily separable. In addition, patient care is not merely a service performed by the physiciansin-training, but is the service as supervised by clinical faculty.

Because GME is inescapably intertwined with the provision of patient care, it is appropriate that patient care revenues continue to be the major source of funding for housestaff. Curtailment of patient care revenues for funding housestaff would have a devastating effect on the viability of many residency training programs.

Prior to 1983, Medicare paid for all inpatient hospital services, including GME, on a retrospective, reasonable cost basis. With the implementation of a prospective payment system (PPS) in which reimbursement for all hospitals is based on predetermined rates for each diagnosis related group (DRG), the problem has surfaced as to how to pay appropriately for services at teaching hospitals. Higher costs of teaching hospitals due to the additional services and functions they perform would not be compensated under a purely DRG based prospective payment system. Congress recognized the complexity of GME financing and the difficulty of paying appropriately without adequate financial data. The Department of Health and Human Services was directed, therefore, to conduct a study of the issue and to prepare recommendations to Congress for handling GME under PPS.

In the interim, Congress provided that teaching hospitals could continue to bill Medicare for its share of the direct costs of medical education on a retrospective, reasonable cost basis. Further, recognizing the difficulty of accounting for differences in severity of illness, case mix differences, and higher overhead costs associated with teaching programs, Congress doubled the limits established under TEFRA (PL 97-248) to reimburse teaching hospitals for indirect educational costs. This formula, in actuality, represents a proxy for the additional costs of teaching hospitals as well as a payment for their indirect educational costs.

The existing method of a "pass through" for direct educational costs and a proxy for indirect educational costs based on number of residents per bed provides few incentives for economy or efficiency in teaching programs. It compensates all teaching hospitals, both inner city and suburban, for educational costs, indigent care, and the resource burden of greater severity of illness regardless of the extent these services add to the costs of operating the hospital. While we maintain that it is impossible to separate the graduate medical education component from patient care services and that payments for patient care at teaching hospitals should reflect appropriately the cost of services rendered, we recognize that better accounting methods for attributing costs must be found, and more appropriate means of financing different kinds of costs must be developed. Still, recognition of the additional cost of GME should be reflected in payments for patient care services at teaching hospitals.

2. Graduate medical education serves the public good, and therefore should receive public financial support.

Although there is no proof of a linear relationship between length of medical training and positive health outcomes for patients, the absence of such proof should not suggest that GME lacks value. There are many things to suggest that GME is highly valuable. For example, it is clear that both the medical profession and the public place a high value on the significance of GME. The profession recognizes the breadth and complexity of knowledge and experience necessary for medical practice, and through a plethora of accrediting and credentialing mechanisms, attempts to assure these qualifications. The profession continues to seek the improvement of systems to accredit training programs, to monitor trainees' progress, and to provide credentials to physicians who meet rigorous professional standards of knowledge and performance. All hospitals, and indeed all organizations that utilize physicians to deliver medical care, depend upon these mechanisms for assurance that physicians are fully qualified. Patients and third-party payers, through their activities and choices in the medical market, attribute greater value to highly trained practitioners. Professional responsibilities for accreditation and credentialing are, to a large extent, validated by the preferences of patients and their choices of well-trained practitioners. Federal agencies such as the VA and other employers of physicians, including health maintenance organizations, also recognize the added value of advanced training and pay higher salaries to board certified physicians.

Second, the public benefits directly from services provided by individuals in GME training programs. Those services encompass care for two groups that are disproportionately served by the teaching hospital: severely ill patients and indigent patients. Severely ill patients require a higher intensity of medical services and a more readily available physician. Physicians-in-training provide both highly intensive involvement with patients and round-the-clock, on-site, accessibility. The indigent population is a disadvantaged group whose access to care is enhanced by the educational programs of teaching hospitals. Housestaff of teaching hospitals provide primary health care to large numbers of this population in areas where there is a lack of access or a lack of providers.

Third, the setting within which GME takes place, the teaching hospital, is valued as a national resource. The teaching hospital, in providing both clinical care and GME, brings together a constellation of medical care resources and personnel that fosters a unique environment for innovation. The teaching hospital promotes innovation not only in the development and dissemination of medical technologies (drugs, devices, and procedures), but also in important medical concepts (methods of diagnosis and treatment; the process of medical decision-making; the importance of social, legal, ethical, and economic considerations) along with the pursuit of academic and professional excellence. The teaching hospital is the site where most of the nation's clinical research takes place, most of its drugs and medical devices are tested, and most of its medical and surgical procedures are conceived, developed, and refined. Additionally, the teaching hospital is the locus from which these innovations, critically important to the improvement of patient care, are disseminated. The development of these new technologies and medical care approaches is expensive, particularly before economies of scale and experience in using them enable their more efficient production. The teaching hospital provides an intellectual environment that encourages necessary pursuit of medical knowledge.

3. The complexity of modern medical care necessitates that all graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) should complete residency training in an approved graduate medical education program prior to engaging in independent medical practice. Adequate financial support must be available to maintain residency training programs to fulfill this educational requirement.

Because of the importance we as individuals and as a society attach to our health, it is essential to ensure that those who furnish medical care are highly qualified. Multiple mechanisms exist to provide this protection.

The Liaison Committee on Medical Education (LCME) establishes and maintains standards of quality for undergraduate medical schools. LCME standards are designed to ensure that all medical school graduates are fully prepared in the basic medical sciences and have had sufficient exposure in the clinical sciences to pursue a program of GME. All undergraduate medical school programs that grant the degree of doctor of medicine in the United States and Canada are accredited by the LCME.

The Accreditation Council for Graduate Medical Education (ACGME) provides similar assurances that GME programs meet certain standards of quality. There are 1,530 institutions and agencies that sponsor 4,759 residency programs approved by the ACGME. To obtain accreditation, each program must meet "General Requirements" that are prerequisites for all programs regardless of specialty. They must also meet "Special Requirements" that provide standards concerning curriculum content, required resources and personnel, duration of training and other requirements specific to each specialty. Each specialty has a Residency Review Committee (RRC) that evaluates all programs to determine if they meet the established "General" and "Special" requirements. Most fully accredited programs are reviewed every five years; those with provisional or probationary status are reevaluated at shorter intervals.

This accreditation process ensures that the care received by patients from physicians-in-training is adequately supervised and is of high quality, and among other things, that patients are not exposed to additional risk because of the training environment. Indeed, patients benefit by receiving care that involves an expert medical team familiar with the latest developments in medical science at facilities that are staffed and equipped to provide a full range of medical services.

The United States historically has attempted to assure a minimum level of competence of physician practitioners through state licensure in addition to accreditation of training programs. However, most states require graduates of U.S. medical schools to complete only one year of graduate training to qualify to take a medical licensure examination. Only two states (Connecticut and New Hampshire) require two years of graduate training; eight states have no minimum GME requirement (Indiana, Louisiana, Massachusetts, Missouri, New York, Ohio, Tennessee, and Texas) (2).

The College believes that the breadth and complexity of modern medical practice now necessitate that the minimum level of required GME be increased and that the completion of an approved residency program be a prerequisite for licensure for fully independent clinical practice. The commitment of the individual practitioner to this degree of graduate medical education would thereby more nearly equate with the profession's assertion that graduate medical education is in the public interest. The medical profession and medical students have in general recognized the need for residency training. The Liaison Committee on Medical Education (LCME) has also stated that it considers the undergraduate period of medical education insufficient to prepare a student for independent practice without additional graduate training.

The American College of Physicians believes that graduate medical education is necessary for the provision of care of appropriate quality and, therefore, we support a requirement that all practicing physicians be adequately trained in accredited residencies.

4. The issue of the funding of graduate medical education cannot be disassociated from a discussion of national health manpower policy. National health needs should be addressed in a comprehensive manner involving long-range planning and coordination of the supply and specialty distribution of medical manpower. Consequently, national health manpower policy must address the aggregate size of undergraduate medical school enrollments, the number of graduate medical education training positions, as well as the number of foreign medical school graduates permitted entry into the United States.

Arguments against the continued funding of GME from public funds are based, in part, on the widely held perception that the United States will soon have a surplus of physicians. Such arguments typically assert that the competitive marketplace will adequately ensure an appropriate balance between the supply and demand for physician personnel.

We have serious doubts that the economic forces of the competitive marketplace will produce the appropriate numbers or the specialty and geographic distribution of physicians that best serve the nation's medical manpower needs. In an increasingly competitive environment, there are pressures for hospitals to curtail programs that do not generate sufficient revenue and to expand those that are revenue producing irrespective of the impact on the availability of needed medical services. Competition in the medical marketplace does not assure that all people in need of medical care will have access to an appropriately trained physician or to appropriate medical services.

In the extreme case, withdrawal of public funding of GME would limit opportunities for a medical career for those unable to obtain their own financing. Opportunities would thus be restricted for minority and financially disadvantaged groups, as well as for most students from middle-income families. We believe that opportunities for medical careers should remain available to physicians from all socioeconomic backgrounds regardless of ability to pay. Rather than terminating funding of GME, a more appropriate response to the impending numerical surplus should be to develop a comprehensive national health manpower policy in which the supply of health professionals is coordinated with national health manpower needs.

All appropriate elements of society, including teaching hospitals, federal and state governments, and the Veterans' Administration, should be involved in addressing the overriding issue of the appropriate total numbers and geographic distribution of physicians, including the appropriate mix of specialties and subspecialties. We believe that decision-making on this issue should be performed neither solely by government nor by the medical profession, but should include both those elements as well as others. A national body should be convened to propose policy actions based on data derived from studies of national manpower needs.

The lengthy educational period involved in preparing today's physicians (approximately 10-15 years after high school) necessitates that any national health manpower policy involve long-range planning of national health care needs and health manpower supply. Such planning should encompass not only planning for physicians, but for all health care professionals. National policy should recognize an obligation to maintain opportunities for those students currently enrolled in accredited medical schools to complete their medical training. Consequently, adjustments in physician supply should link the number of GME training positions to the number of students graduating from approved medical schools.

As a beginning step, we recommend that the total number of positions for each year of residency be limited to the total annual number of graduates of schools approved by the LCME and the American Osteopathic Association (AOA), since those numbers (roughly 17,000 per year) appear to ensure at least an adequate supply of physicians. Consideration might be given to increasing these numbers slightly to permit sufficient flexibility for physicians to obtain residencies in their chosen field of specialty. Future adjustments in physician manpower supply should be implemented in accordance with a long-term national health manpower policy by funding mechanisms creating incentives or disincentives to influence undergraduate medical school enrollments.

We believe that this nation should maintain its preeminence in international medical education, and should not abandon its role as a trainer in the medical sciences of physicians from foreign countries. Consequently, we believe that there should be sufficient residency training positions in the United States to accommodate limited numbers of foreign medical graduates. Opportunities for GME in the United States for foreign physicians should exist primarily for those who will return to their country of origin upon completion of training.

We strongly recommend that attention be given to determining the appropriate number of FMG's permitted and that consideration be given to developing alternative sources of financing for their training. We urge also that serious consideration be given to whether or not publicly supported GME training should be available to U.S. citizens who obtain medical training abroad at unaccredited medical schools.

We believe most strongly that physician manpower issues are of national consequence, that the market for physicians is a national market, and that the degree of variation among the states in numbers and types of medical schools, teaching hospitals, and resident mix is such that issues of physician manpower should not be left for decision solely at the state level. However, because of varying state need, neither should all decisions of manpower policy and implementation of that policy be made solely at the federal level. We, therefore, urge development of a national health manpower policy with appropriate state and local input and flexibility.

5. The funding of graduate medical education must be a part of discussion of issues of physician reimbursement.

It is likely that incentives and disincentives built into the present system of third party reimbursement are factors that figure in specialty and subspecialty choice by physicians as they begin graduate medical education. Thus, changes in the system of reimbursement are likely to lead to changes in specialty and subspecialty choice. Likewise, it is probable that changes in the support for GME, to the extent that those changes place a greater financial burden on the physician-in-training, also may lead to changes in subspecialty and specialty choice. Revenues from patient care services also could influence the availability of residency training positions.

Consequently, we urge that the physician reimbursement system be reexamined and that a system be developed that minimizes the effects of finances on medical decision-making. The reimbursement system should not dictate either GME training sites nor the medical education curricula. Currently, inpatient GME is funded by Medicare Part A and other third-party payers, but training in the outpatient setting receives only limited funding. Training in outpatient settings usually depends on either special grants or upon funds from inpatient programs. On rare occasions, limited funds are available from faculty patient care revenues. We believe that medical educators should be able to determine the appropriate sites of GME training, and that the reimbursement system should not unduly influence these decisions.

We as a professional medical society and as individual physicians should not allow economic incentives or disincentives to improperly affect the medical decision-making process. Neither should we countenance a reimbursement system that allows economic incentives to influence inappropriately the specialty distribution of physicians. We, therefore, urge that a changed structure of funding of GME not ignore the effect of the reimbursement system on physician career choice and thus specialty mix.

VIEWS ON S. 1158:

Mr. Chairman, we would now like to provide some specific comments on the provisions of S. 1158, legislation to alter the method by which Medicare provides payments for the direct costs of approved educational activities. We are pleased that the sponsors of the measure have attempted to address some of the critical issues with regard to Medicare's role in financing graduate medical education and we are particularly appreciative of their acknowledgement that these issues will require careful discussion and analysis prior to the initiation of changes.

At this time, we would like to make the following observations:

1. We support the intention of the sponsors to restrict the length of the training period that will be supported by Medicare payments, as we believe that this is the logical implementation of existing federal policies to provide incentives for training in the primary care specialties. However, we are concerned that the period of support outlined in the legislation -- namely, the lesser of initial board eligibility or five years -- may have implications beyond those envisioned by its sponsors. We are concerned that it may provide unintentional incentives for certain surgical subspecialties while eliminating support for medical subspecialties and training in fields such as geriatrics that are vitally important to the mission of the Medicare program and to the anticipated future health care needs of the nation.

2. We strongly support those provisions of the legislation that would end Medicare support for the training of alien foreign medical graduates. However, we believe that the issue of training of alien foreign medical graduates requires further discussion. It is our view that although it is appropriate to curtail Medicare's support of those who have not graduated from LCME-approved institutions, we must carefully examine the appropriate role of this nation in sharing its resources and expertise in medical education with other nations. If the United States is to maintain its commitment to the international public health, then training opportunities

for alien foreign medical graduates who will return to practice in their own countries must be provided. However, it does seem that other mechanisms can be found, outside of the Medicare program, for continuing this international leadership role. The College would be pleased to work with the Committee to help identify such other mechanisms.

3. We strongly disagree with those provisions of the bill that permit the continuation of Medicare support for the graduate training of United States citizens who have received their medical education in unaccredited institutions outside of the United States and Canada. We realize that this is an extremely sensitive issue, with significant implications for some citizens of this nation. However, we urge that there be full discussion by the Committee of this matter.

At a time when we are adopting national and state policies that will curtail the projected surplus of physicians -- including reducing the class size of a number of United States medical schools -- it would appear to be contradictory policy to continue to provide financial support through Medicare for the advanced education of individuals who are graduates of unaccredited non-U.S. medical schools.

The American College of Physicians is fully cognizant of the fact that this is a difficult and complex issue; however, we ask that in further considering S. 1158, that the Committee modify the provisions with regard to U.S. foreign medical graduates. Again, we would be pleased to offer whatever assistance we can as the Committee works to address this issue.

4. We support those provisions requiring studies of approved educational activities for nurses and other health professionals, and of the difference

in costs in teaching and non-teaching hospitals. However, with regard to this latter study requirement, we concur that care must be taken to ensure coordination of such information gathering with other studies on teaching costs and teaching physicians' services that are already in progress. In addition, we would suggest that the Committee request a study of the alternative methods for financing the education of health professionals. As you know, such an analysis was recommended by the Advisory Council on Social Security in 1982, and information developed through such a study may prove critically important to future discussions of the financing of graduate medical education. It would be most useful to have a careful analysis of the implications of other sources of funding beyond the Medicare trust fund.

5. Finally, we support the concept of a freeze on Medicare payments for direct medical education for one year as a means of achieving short-term budgetary savings. In the context of larger national needs to reduce the size of the federal deficit and other programmatic freezes, such a provision is equitable.

In addition, we strongly agree that a period of transition will be needed for the implementation of any long-term changes in the method of financing graduate medical education. It is our belief that this one year freeze provides such a period for transition, although in certain specific instances, such as the treatment of foreign medical graduates, further discussion may indicate that additional transition time will be needed.

Mr. Chairman, that concludes our comments on the specific provisions of the legislation as introduced. We wish to reiterate our appreciation for the efforts made to date by the sponsors of the proposal, and stand ready to provide whatever information may be helpful as these matters are further discussed.

SUMMARY

In conclusion, Mr. Chairman, the American College of Physicians appreciates that the issue of financing graduate medical education is being considered in a substantive way, with the practical ramifications of policy changes being addressed. We recognize that the principles that lead to the formulation of policy operate within budget constraints, but we do not believe those constraints should have an inappropriate effect on those principles. Thus, we would emphasize two principles we see as fundamental in these discussions: graduate medical education is linked with patient care, and graduate medical education serves the public good. We believe these principles support a policy of patient care revenues and public moneys supporting at least a share of graduate medical education.

The issues of specialty manpower mix, foreign medical graduates, and U.S. citizen graduates of foreign medical schools, must also be addressed, and we are pleased to see that the sponsors of S. 1158 have opened the discussion of these issues.

The College is pleased to have had this opportunity to present its views and offers its assistance to the Committee during your future deliberations. I would be pleased to respond to any questions that you may have.

Senator **Durenberger**. Let me thank all of you for staying within 5 minutes. I think only physicians could accomplish that precise time schedule. I appreciate that.

I want to start off with a comment. I am going to Dr. Sledge's testimony where he was raising the question about the purposes for what we are doing—are we trying to save money for Medicare, or are we trying to limit the amount of medical manpower in this country, or are we trying to redistribute it? I think the answer to that, at least from my standpoint, is none of the above. The freeze part obviously has something to do with shared sacrifice, freezing, budget constraints, deficit reduction, and I am only participating in that part of it. I'm not using it as a rationale for reforming medical manpower.

From my standpoint, this is a cooperative effort, not a governmental effort, to get more efficiency out of the use of financial resources in medical manpower; and, from a personal standpoint, again, it is an effort to save particularly those—often university-based—medical colleges in this country that would not survive in a price-competitive system unless society did something about explicitly standing up to its obligation to fund medical education.

So I know you probably knew that. This is for others' consumption. But I wanted to start with that point.

Let me start, then, with Dr. Kettel. On the subject of residency program size adjustment, your written testimony suggests the 1-year freeze on direct payments for clinical education, and S. 1158 would prohibit programs from adjusting their sizes to meet changing conditions. The implication there is that the cap, being set on a hospital-by-hospital basis, may cause the problem.

Do you see some way to achieve the budget savings resulting from the freeze position but providing more flexibility for program size adjustments?

Dr. **Kettel**. Mr. Chairman, the issue is very complicated indeed, and it is one of the agenda items for the AMA's ad hoc committee. My concern is that, simply by limiting the cap to the hospitals' full dollars, it may preclude the flexibility the system needs right now. There are programs closing and opening, there are disaccredited, accredited, and probationary programs, things of that sort, and I think we need that degree of freedom if the marketplace is to make the adjustments I think it is making. We, for example, will be closing programs in Arizona and opening others over the next couple of years, and I would not like to be locked in by a cap that I don't understand. But I would like to say the AMA will be coming up with a policy in that area.

Senator **Durenberger**. I won't ask the FMG question of AMA, because you may have pulled that data together, but is it true that the majority of alien foreign medical graduates that come to this country for their graduate medical education do not return to their countries to train their students?

Dr. **Kettel**. I think that is a fair statement, sir.

Senator **Durenberger**. Is that increasing? Has it always been the case?

Dr. **Kettel**. Mr. Chairman, I am not sure I can give you the history of it. I think it is a fact at the moment, but I think you heard earlier that the numbers of FMG's have declined over recent years, but the numbers that are staying in this country I would guess is still a very high proportion, perhaps 90 to 95 percent.

Mr. **Peterson**. I think that may be a little high. I understand that at least 60 percent of the alien FMG's can be identified as those having permanent residency. Then there are another 30 percent that are pretty hard to track as to their exact status. There probably are 10 percent that are alien FMG's who return, but I think that is the minority figure.

Senator **Durenberger**. Well, I met a bunch of them in Central America, and maybe that is a unique part of the world, but they haven't got any other place to go; they usually go to Houston. I don't want to just pick on Houston, but that just happened to be where the fellows from San José went. But they went back.

The testimony we have heard so far today indicates that there is no U.S. need to go out and recruit aliens who are foreign medical graduates to come in here and satisfy a need that we have in this country. There is a need in just our social conscience, if you will, for us to provide opportunities in this country for these doctors that I met in San José and San Salvador and some other places, because they don't have any other place readily available to them. But those are two somewhat different issues, and I think the issue here is whether or not Medicare should finance those Costa Rican doctors, or should we have some other program to finance the Costa Rican doctors? Have I sort of barely stated it from the viewpoint of most of your association?

Dr. **Kettel**. I believe that would be our point of view.

Senator **Durenberger**. On the question of the other congressional proposals for reform of Medicare funding—I asked this question of the previous panel and maybe you heard it; those of you who want to comment on it may—there are two tracks that they go on: One would make the Medicare payment dependent on having a fixed proportion of residents in primary care and a fixed proportion of graduates of U.S. and Canadian medical schools. The second track would fund primary care residents at a higher level than specialty residents and would establish a national rate for stipends and fringe benefits for residents. Do any of you have an opinion, and I will start with AMA, about that kind of an approach as opposed to the approach we are taking in S. 1158?

Dr. Sheldon?

Dr. **Sheldon**. I think, as the last panel commented, it is very hard to know what kind of doctor we are going to need 20 years from now, and this is one of the fundamental flaws in all the Federal and other manpower projections that have been made.

Incidentally, the March HHS manpower study differs between 5 and 20 percent from the earlier studies that have been done, showing really the inexactitude of this type of study which 20 years ago said we needed 50,000 more doctors.

The fixed proportion issue I think is also difficult. As Dr. Sledge pointed out, many specialties of surgery do a lot of primary care. In my department, the Division of Orthopedic Surgery runs 23 clinics a week, all outpatient clinics, and in the four institutions with which I have been associated, the Department of Surgery saw equal if not more outpatients than any of the other specialties which kind of come under the definition of "primary care." And I get calls at night for colds and other things, just like every other doctor, that are related to patients.

I would point out that it is something that is very hard to decide, what we are going to need in the future, and until we have more exactitude in estimating advances that might come along, I think it is difficult to ration specialties.

Senator DURENBERGER. Dr. Hook?

Dr. HOOK. Yes. I think we feel that any approach toward controls is problematical, but in looking at the various alternatives, it seems to me that it would be more reasonable to attempt to control the maldistribution of primary care physicians and subspecialists by a fixed proportion approach rather than by attempting to control it through limiting the period of training.

Senator DURENBERGER. Well, our bill does not attempt to limit training in any way; our bill just said we are going to pay for so many dollars of training. [Laughter.]

I mean, I have to ask Dr. Ruberg: If we are willing to invest 5 years in the reconstructive surgery business, is somebody going to quit at that point, or is nobody going to go in because that last year is not financed? Is it likely that somebody in your area of specialty will say, "Why do we have to put this particular 6-year package together? Might we not be able to accomplish the same end, given where the demand for our services lies out there, in a lesser amount of time?"

Dr. RUBERG. I think you have asked two questions. As regards the length of time, that has been very carefully considered by our specialty, and in fact recently reviewed within the last several months, and the current opinion is very clearly that it takes 6 years minimum to train people in our specialty. In fact, in many of our programs, people train for 7 or more years.

We have chosen to support the physician, that we would support funding for just the minimum years that our board has determined.

The other issue, as to what will happen to programs that are "unfunded," we have great concern that in some of our institutions, some of the plastic surgery programs may be abandoned through the effort of the institution, because our programs are unfunded or partially unfunded. That is really a great concern, that the specialty will find that we are able to train fewer practitioners because programs will be eliminated. I don't think it will be as much pressure upon the residents as it will be upon institutions who perhaps abandon programs which are not longer funded by Medicare.

Senator DURENBERGER. Is there a great demand in America today for reconstructive surgery professionals who have had 7 years of postgraduate education?

Dr. RUBERG. We certainly believe there is. In our written statement, we have outlined a number of areas, including burn reconstruction, reconstruction after cancer surgery, plus lip and palate surgery, in which our specialists, to a large part, participate.

Senator DURENBERGER. Dr. Sledge.

Dr. SLEDGE. I would like, please, to comment on your question of what would happen if you limited the Medicare reimbursement to a number of years less than primary-board certification.

I think there are at least three potential outcomes. It partly depends on the popularity of the specialty. There are differences in popularities of specialties—those that are extremely popular and oversubscribed in a very competitive mode would probably see very little change. Other mechanisms of financing would be found, or something else; the burden would be shifted somewhere else. Those that are unpopular would do as you suggested, they would look at their curriculum and say, "Hey, I think we can probably cut out a year here, since it is no longer paid for," perhaps.

But there is a third alternative that worries me a little bit, and that is, we might step back at least one generation to a point in time where only those who were congenitally wealthy could become physicians and specialists. If we ask them to fund a significant portion of their own training, then in a popular specialty that wasn't willing to compromise and had too many applicants anyhow, they would take those who could afford that final year themselves. And I think that would be an undesirable effect.

Senator DURENBERGER. I think if that is the only alternative, you are probably correct. If the alternative is that some institutions will tend to specialize in some specialties and attract people who need that special kind of education, then there will be some other form of funding for those programs; and the truth may end up being somewhere in between.

I think Dr. Kettel was first, then Dr. Sheldon.

Dr. KETTEL. I would like to speak just for a moment to the quota or the primary-care percentage, however it is defined.

Any kind of quota or fixed ratio right now would be very difficult in a system that is in great flux. Just let me make one comment: Any of the better teaching hospitals, because they have such intense tertiary care kinds of things, do best to train the tertiary care specialties. And it would be very hard for them to meet a ratio of some primary care to be eligible for any programmatic funding. I think a degree of flexibility is much more important right now than any kind of cap. The marketplace is adjusting, the DRG's and other things are creating different kinds of mixes in the educational environment, and I don't know how to measure all of that right now.

There are also some changes in the boundaries of practice and who can do what. You will hear, I think in the next panel, from nonphysician providers, and they will have some say about who is doing primary care and who isn't. I think that is going to be an important issue that one must look at carefully, and the AMA is very concerned that we don't arbitrarily fix ourselves into a box while the system is in incredible flux because of a financially driven problem rather than what is happening in the industry.

Senator DURENBERGER. Dr. Sheldon.

Dr. SHELDON. I would like to just make a point somewhat comparable to that made, and that is: In 1970, surgical specialties accounted for about 40 percent of the number of training positions. That number has now fallen to 26. At that time it was about 26 percent primary care. So the perceived need to move to primary care is already happening, and it is a very hard thing to control because of the number of years and many other things in the system.

I would like to also point out that the number of years of training is not capricious. A new certificate of special competence in vascular surgery was adopted only a year ago, and that took a full 12 years to work its way through the accrediting processes, the societies, the debates. I think these are not just years added on because someone thinks it is a good idea to spend a little more time.

Senator **Durenberger**. All right.

Dr. Ruberg, just to finish this off—and I am not picking on your profession at all, but you gave me the numbers, so I was able to go off on that—isn't plastic or reconstructive surgery training provided primarily at academic medical centers which have sizable faculty practice plans; that is, group practices? And in the advanced years of training, isn't it true that faculties use residents to extend their practices as well as to train residents? At places like Mayo and Oxnor, the attendings fund the advanced training. Why can't the same be done at other institutions?

Dr. **Ruberg**. I think that very much depends on the nature of the institution. Certainly there are many of our academic institutions in which the majority of patients are indigent patients, patients for whom there is no funding from external sources.

I think to say that the faculty utilizes the advanced years of the residency training program to extend their own practice perhaps may be true in some institutions; it may not be true in the majority of institutions. And certainly those institutions in whom the majority of patients fall under the indigent-care population, this would not be the case.

Senator **Durenberger**. Dr. Hook, on the LCME issue, what are the additional qualifications if any that are required of graduates of medical schools whose programs are not accredited by LCME in order to be eligible to enter U.S. graduate medical education programs? In other words, what are the deficiencies in those institutions that do not get LCME certification?

Dr. **Hook**. Well, I couldn't list at the moment a whole host of specifics relative to that question. The LCME has a set of standards relative to every aspect of education and practice within medical schools, and attempts to see that the schools that are approved by the LCME meet those standards.

One that has been commented on a great deal, one difference, is that capacity for clinical training or clerkship training in the third and fourth years of medical school when our medical schools, the LCME-approved medical schools, are compared with certain foreign medical schools.

Another issue and a striking difference relates to class size, some of the class sizes in certain of the foreign medical schools. And I think the whole rigor of the training process is much more supervised and controlled, in a sense, in the LCME-approved schools as compared to those that aren't.

Senator **Durenberger**. Well, gentlemen, I am going to have to thank you all at this point leaving some of our questions unanswered. But I again express my gratitude to each of you for your testimony.

Our next panel consists of Mr. Robert A. Capone, president of the Federation of Associations of Schools of the Health Professions, accompanied by Tom Nickels, director of legislation for the AMA;

Ellen T. Fahy, the dean of the University of Minnesota School of Nursing, on behalf of the Nursing Tri-Council, accompanied by Diane K. Kjervik, AACN, director of general relations; and Sharon A. Scanlon, Georgetown University Medical School, on behalf of the American Medical Student Association, accompanied by Helen Burstin, national president of the American Medical Student Association.

As I indicated earlier, all of the written testimony of each of the associations represented here will be made a part of the record, and we would appreciate each of you summarizing those statements in 5 minutes, or fewer, starting with Mr. Robert A. Capone, president of the Federation of Associations of Schools of the Health Professions.

STATEMENT OF ROBERT A. CAPONE, PRESIDENT, FEDERATION OF ASSOCIATIONS OF SCHOOLS OF THE HEALTH PROFESSIONS, ROCKVILLE, MD

Mr. Capone. Mr. Chairman, thank you very much. On behalf of the Federation of Associations of Schools of the Health Profession, we appreciate this opportunity to share its views on S. 1158 regarding the funding of graduate medical education under Medicare.

The members of FASHP represent over 300,000 students and 35,000 faculty in some 1,600 schools located throughout the United States and Puerto Rico. The disciplines represented by the federation include optometry, pharmacy, podiatric medicine, nursing, osteopathic medicine, veterinary medicine, public health, and health administration.

Most importantly, FASHP feels that the Medicare Program currently does and should continue to play a role in the development and maintenance of an appropriate cadre of health professionals. Significant and premature disruption of that Federal role, we believe, would prove detrimental to this Nation's ability to respond to its health care priorities. We are pleased that the sponsors of this bill share that general perspective, as reflected in the bill being discussed today.

However, on a more specific level, we are concerned with one provision of this bill, the proposed freeze on Medicare's funding for the direct costs of educational activities at hospitals. For many of our professions, training in a hospital setting is a critical element of our students' education. Indeed, for some of the health professions, such educational activities are a required component of the educational process. To levy a freeze on Medicare payments to hospitals for these training programs could seriously jeopardize their viability.

There continues to be a national need for health professionals such as primary care providers, pharmacists, podiatrists, public health specialists, hospital administrators, and nurses. In part because of their hospital based training, FASHP's health professionals become directors of immunization programs, geriatric nurse-practitioners, primary care providers, health educators, clinically oriented pharmacists, and providers of foot care. In other words, these are the very members of the health care service community who are providing the kind of care so urgently needed. To weaken the potential of hospitals to offer them educational programs and consequently to jeopardize the ability of these health professionals to complete their training could have significant adverse impact on these disciplines.

There is an additional and more immediate concern here, as well, regarding a freeze on Medicare medical education dollars. Under clinical supervision, health professionals who train in hospital-based programs are providing care to Medicare patients. In other words, these patients benefit in a very real and direct way from this Medicare dollar investment. And as the subcommittee knows, the Medicare Program was established for just that, the provision of health care services to the elderly.

The federation would like to express its wholehearted support of this bill's proposal to study the Medicare funding of nursing and other health professions' educational activities. We share the administration's concern that critical information regarding the types and numbers of such programs, the number of students, the affiliations between schools and hospitals, and the types and amounts of expenses for such programs is currently unavailable. Without that detailed information, an accurate assessment of Medicare's contribution to these very important educational activities is impossible.

However, we would caution the Secretary of Health and Human Services to approach such a study with care and prudence. Many of the member associations of the federation would appreciate the opportunity to provide the Secretary with assistance in collecting such information. Indeed, some member groups have already begun this process in recognition of the need for such information. We believe the health professions schools, and their associations could and indeed should contribute to this very important endeavor.

The federation applauds the subcommittee's recognition of the importance of health professions training and its efforts to develop policy which is responsive to the changing health care environment. Our member schools and associations certainly are cognizant, as are you, of current economic and political realties. We believe that the health professions' education community, the Congress, and the administration can work together to address the issues currently before us. The federation stands ready to participate in that cooperative effort.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much.

Dean Fahy.

[The prepared statement of Robert A. Capone follows:]

STATEMENT OF
FEDERATION OF ASSOCIATIONS OF SCHOOLS OF THE HEALTH PROFESSIONS

BEFORE

THE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

UNITED STATES SENATE
ON S.1158

MEDICARE FUNDING FOR GRADUATE MEDICAL EDUCATION

JUNE 3, 1985
Washington, D.C.

FEDERATION OF ASSOCIATIONS
OF SCHOOLS OF THE HEALTH PROFESSIONS
6110 EXECUTIVE BOULEVARD, SUITE 204, ROCKVILLE, MD 20852 / (301) 984-9350

Mr. Chairman, the Federation of Associations of Schools of the Health Professions (FASHP) appreciates this opportunity to share its views of S.1158, regarding the funding of graduate medical education (GME) under Medicare. The members of FASHP represent over 300,000 students and 35,000 faculty in some 1600 schools located throughout the United States and in Puerto Rico. The disciplines represented by the Federation include optometry, pharmacy, podiatric medicine, nursing, osteopathic medicine, veterinary medicine, public health, and health administration.

Clearly, the health professions of which FASHP is comprised are diverse and, for that reason, this testimony will address only those aspects of S.1158 on which a consensus is important. For those provisions on which individual health professions associations wish to express their perspective, individual testimonies will be submitted.

Most importantly, the FASHP feels that the Medicare program currently does, and should continue to, play a role in the development and maintenance of an appropriate cadre of health professionals. Significant and premature disruption of that federal role, we believe, would prove detrimental to this nation's ability to reponsd to its health care priorities. We are pleased that Senators Dole, Durenberger, and Bentsen share that general perspective, as reflected in their bill being discussed today.

MEMBER ORGANIZATIONS
American Association of Colleges of Nursing • American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy • American Association of Colleges of Podiatric Medicine
Association of American Veterinary Medical Colleges • Association of Schools and Colleges of Optometry
Association of Schools of Public Health • Association of University Programs in Health Administration • National League for Nursing

However, on a more specific level, we are concerned with one provision of this bill: the proposed freeze on Medicare's funding for the direct costs of educational activities at hospitals. For many of our professions, training in a hospital setting is a critical element of our students' education. Indeed, for some of the health professions, such educational activities are a required component of the educational process. To levy a freeze on Medicare payments to hospitals for these training programs could seriously jeopardize their viability.

There continues to be a national need for health professionals such as primary care providers, pharmacists, podiatrists, public health specialists, hospital administrators, and nurses. In part because of their hospital-based training, FASHP's health professionals become directors of immunization programs, geriatric nurse-practitioners, primary care providers, health educators, clinically oriented pharmacists, and providers of foot care. In other words, these are the very members of the health care service community who are providing the kind of care so urgently needed. To weaken the potential of hospitals to offer them educational programs and consequently, to jeopardize the ability of these health professionals to complete their training is short-sighted.

There is an additional, and more immediate, concern here as well regarding a freeze on Mediare medical education dollars.

Under clinical supervision, health professionals who train in hospital-based programs are providing care to Medicare patients. In other words, these patients benefit in a very real and direct way from this Medicare dollar investment. And, as the Subcommittee knows, the Medicare program was established for just that: the provision of health care services to the elderly.

The Federation would like to express its whole-hearted support of this bill's proposal to study the Medicare funding of nursing and other health professions educational activities. We share the Administration's concern that critical information regarding the types and numbers of such programs, the number of students, the affiliations between schools and hospitals, and the types and amounts of expenses for such programs is currently unavailable. Without that detailed information, an accurate assessment of Medicare's contribution to these very important educational activities is impossible.

However, we would caution the Secretary of Health and Human Services to approach such a study with care and prudence. Many of the member associations of the Federation would appreciate the opportunity to provide the Secretary with assistance in collecting such information. Indeed, some member groups have already begun this process in recognition of the need for such information. We believe the health professions schools and their associations could and indeed, should contribute to this very important endeavor.

The FASHP applauds this Subcommittee's recognition of the importance of health professions training and its efforts to develop policy which is responsive to the changing health care environment. Our member schools and associations certainly are cognizant, as are you, of current economic and political realities. We believe that the health professions education community, Congress, and the Administration can work together to address the issues currently before us. The FASHP stands ready to participate in that cooperative effort.

Thank you.

STATEMENT OF ELLEN T. FAHY, DEAN, UNIVERSITY OF MINNESOTA SCHOOL OF NURSING, MINNEAPOLIS, MN, ON BEHALF OF THE NURSING TRI-COUNCIL, WASHINGTON, DC, ACCOMPANIED BY DIANE K. KJERVIK, AACN, DIRECTOR OF GENERAL RELATIONS

Dean FAHY. Mr. Chairman, I am Dr. Ellen Fahy, dean of the School of Nursing of the University of Minnesota in Minneapolis and St. Paul. I testify today on behalf of the Nursing Tri-Council, which consists of three organizations: The American Association of Colleges of Nursing, the American Nurses' Association, and the National League for Nursing.

Mr. Chairman, we commend you and Senators Dole and Bentsen for your initiative in reexamining Medicare's role in the funding of health professions education in the clinical setting. We appreciate the thoughtful approach you have taken in this area, especially with regard to the careful examination of nursing education needs. We believe S. 1158 to be realistic in what it sets out to achieve and welcome the opportunity to make a contribution to the proposed study of nursing education called for in the bill.

Information regarding the financial benefits to the hospital for the clinical placement of nursing students, the costing out of such arrangements, and other fiscal and administrative data are currently lacking but are critical to formulating an informed and rational policy for financing nursing education under Medicare.

We wholeheartedly support the bill's provision that the Department of Health and Human Services conduct a study to improve our understanding of educational activities reimbursable by Medicare for nursing and other health professions, while continuing the present policy of paying these costs outside the DRG rate.

The National League for Nursing is currently conducting a survey of nursing education programs. All three organizations of the Nursing Tri-Council confirm their willingness to share data from the National League for Nursing and other surveys in assisting the Congress and the Department in the development of studies and analysis of data of nursing educational activities under Medicare, as directed under S. 1158.

Cutbacks in GME which are inadvertently applied to nursing could mean that nursing schools will be faced with having to bear a greater financial responsibility for their students' clinical experiences. This extra financial burden will either force schools to close or at least to diminish in size, or to pass along the cost to students in the form of higher tuition or fees. Adding these costs to nursing education programs not only would be a significant financial burden but also could be a serious deterrent in the recruitment of students, especially disadvantaged students from low-income and poverty level families.

The committee, we feel, needs to be aware of the likelihood that cutbacks in GME may fall disproportionately on nursing and allied health education programs, as hospitals might seek to maintain present commitments to medical residency programs. Given this possibility, we prefer that the cost of nursing education not be subject to a freeze; however, we hope, if there is a freeze, it would be the committee's intent to apply it evenhandedly across all health professions' education programs.

It is important to note the differences between the costs of medical and nursing education, and the role of students for both professions in hospital settings. Medical education is generally more expensive, with higher costs incurred by hospitals. Graduate medical students receive salaries for most of the services they provide to patients, while nursing students indeed pay tuition which includes the costs of their clinical practice.

Both nursing and medical education programs relate to each other by virtue of sharing resources and responsibilities of a teaching hospital. Most studies to date have not sufficiently addressed the indirect costs of nursing education, but instead have focused solely on graduate physician education; therefore, we would urge that the studies undertaken by the GAO to examine indirect education costs and the differences between teaching and nonteaching hospitals also take into account what the impact of these differences are on the utilization of nursing resources, both for nursing education and for nursing services.

We feel a word of caution is necessary regarding assumptions of the physician surplus as it pertains to Medicare's reimbursement of GME's. In nursing, in particular specialties, and in the case of practitioners prepared at advanced levels, there are serious shortages and a maldistribution of nursing personnel. This is especially true for nurses with special training in geriatrics and long-term care, which are in highest demand by Medicare beneficiaries.

Recognizing beneficiaries' needs for care beyond the hospital setting, we recommend your adding to the bill a separate section (d) regarding additional studies. These studies would report on methods by which Medicare could finance its share of nursing educational costs in ways that facilitate adjustments in training sites and curriculum to reflect changes in health care practice patterns and the particular needs of the elderly.

Before any policy changes can be implemented regarding nursing education and Medicare, changing trends in nursing education—since Medicare was enacted 20 years ago—must be taken into account.

Since 1965, the locus of nursing education has increasingly shifted from hospital-based programs to institutions of higher education. There has been a rather large increase in the numbers of students in nursing programs located in institutions of higher education, and Medicare dollars do not necessarily reflect the developments. An understanding not only of where current funds are being spent but also of how nursing education has changed must be taken into consideration in assuming equity.

Given these factors, the Nursing Tri-Council strongly supports the recommendation for the future study on nursing educational activities under Medicare as specified in S. 1158. We also recommend that any future changes in Medicare's policies toward financing nursing education be implemented only after careful analysis of data collected, and that such changes take account of recent trends in nursing education.

Thank you for the opportunity to present our views, and we will gladly answer questions.

Senator **Durenberger**. Thank you very much. Sharon, welcome.

[Dean Fahy's written testimony follows:]

Testimony on Behalf of the Nursing Tri-Council on the Subject of Medicare's Pass-Through for Graduate Medical Education (S. 1158)

Mr. Chairman, I am Dr. Ellen Fahy, Dean of the School of Nursing at the University of Minnesota. I am testifying today on behalf of the Nursing Tri-Council, consisting of three organizations: The American Association of Colleges of Nursing (AACN) representing 382 college or university schools of nursing; the American Nurses' Association (ANA), representing 185,000 registered nurses through 53 constituent state nurse associations', and the National League for Nursing (NLN) the nationally recognized accrediting body for nursing education representing nearly 2,000 agency and 17,000 individual members.

Mr. Chairman, we commend you and Senators Dole and Bentsen for your initiative in reexamining Medicare's role in the funding of health professions education in the clinical setting. We appreciate the thoughtful approach you have taken in this area, especially with regard to the careful examination nursing education needs. We believe S1158 to be realistic in what it sets out to achieve and welcome the opportunity to make a contribution to the proposed study of nursing education called for in the bill.

Your principle focus at these hearings and in your bill is on post-graduate education of physicians. In several respects, however, the education of nurses and other health professionals must be considered separately as you evaluate health personnel needs and the most appropriate and equitable financing mechanisms for these programs. In fact, actions that may be taken with respect to graduate physician education support could have very profound effects on nursing education in the hospital setting.

By way of background, it is important to recognize that Medicare payments to teaching hospitals for the direct costs of graduate physician education programs include funds for nursing education and the training of many other professions. At this time, there are few data available on the proportion of Medicare's payments applied to nursing and the allied health professions programs.

Lack of Available Data

Information regarding the financial benefits to the hospital for the clinical placement of nursing students, the costing out of such arrangements, and other fiscal and administrative data are currently lacking but are critical to formulating an informed and rational policy for financing nursing education under Medicare. This was one of the major points made when NLN and ANA testified before your Committee on this subject last fall and we appreciate your sensitivity to our concerns as reflected in S1158. Therefore, we wholeheartedly support the bill's provision that the Department of Health and Human Services conduct a study to improve our understanding of educational activities reimbursable by Medicare for nursing and other health professions, while continuing the present policy of paying these costs outside the DRG rate.

In order to gain a more precise estimate of the true costs of nursing clinical education and the contributions made by Medicare to cover these costs, the National League for Nursing is currently conducting a survey of nursing educational programs. The findings of this survey will be only a first step. Responses to the survey were obtained from nursing educational directors and not directly from the financial or administrative personnel of the hospitals. Even though in the process of completing the questionnaires, nursing educational directors obtained information from hospital administrators and financial officers, the need to quantify the extent of present payments in more detail is critical if a sound approach to policy formation in this area is to be pursued.

All three organizations of the Nursing Tri-Council confirm their willingness to share data from NLN and other surveys in assisting the Congress and the Department in the development of studies and analysis of data of nursing educational activities under Medicare, as directed under S1158.

Impact of GME Cutbacks on Nursing

Meanwhile, we do know that the nursing component of Medicare's overall graduate medical education (GME) payments to hospitals is proportionately small compared to medicine's educational costs. The Health Care Financing Administration's (HCFA's) most recent statistics indicate that for 1984, Medicare's share of the cost of nursing education was estimated at $250 million. HCFA staff warn that this reflects data for 1981, indexed to 1984 and may be subject to wide variations in report uniformities. Yet, we know these funds are critical to the financial viability of many programs. It would be unfortunate, indeed, if funding for these clinical education programs in nursing were to be reduced on the basis of policies designed for and aimed at graduate medical educational programs, not necessarily correlating to nursing.

Cutbacks in GME which are inadvertently applied to nursing could mean that nursing schools will be faced with having to bear a greater financial responsibility for their students' clinical experiences. We are referring here to situations where due to overall financial restraints, hospital administrators have threatened to charge nursing schools a per capita charge as high as $100 for each student who uses a hospital for the clinical practicum. In many cases, this extra financial burden will either force schools to close or to pass the costs along to students in the form of higher tuition or fees. Adding these costs to the nursing educational program not only would be a significant financial burden, but also could be a deterrent in recruitment of students, especially of disadvantaged students, from low income and poverty level families.

Clinical costs of nursing educational programs are more vulnerable to hospital administrators' efforts to reduce administrative costs. In a tighter economic health care environment, given the choice as to where cuts might be made, clinical practica for affiliated nursing programs are likely to suffer because they do not generate as much revenue as do other medical departments or medical educational programs.

Furthermore, cutbacks in GME experienced by nursing in a given hospital could result in fewer dollars for the nursing educational staff--who are essential parts of any nursing clinical practica. This reduction in staff severely compromises the hospital nursing department's ability to provide safe meaningful clinical learning experiences and could jeopardize quality of nursing care to Medicare patients.

Not only are the use of Medicare funds for nursing education important for maintaining a certain quality of nursing care, but there can be no doubt that a nursing school's participation with a particular hospital for clinical practice greatly increases the likelihood that graduates of the nursing program will seek employment in that particular hospital. These new graduates are already familiar with the hospital's standards and procedures and as nurses are an important, if not the most essential ingredient, in Medicare beneficiaries hospital care.

Direct Educational Costs

The Committee needs to be aware of the likelihood that cutbacks in GME may fall disproportionately on nursing and allied health education programs, as hospitals seek to maintain present commitments to medical residency programs. Given this possibility, we would prefer that the costs of nursing education not be subject to a freeze. However, we hope that if there is a freeze it would be the Committee's intent to apply it evenhandedly across all health professions educational programs within the hospital and not to allow for increases in graduate medical education (GME) at the expense of reductions for nursing or other health professions' educational activities.

Furthermore, our understanding of the bills intent is that Medicare would continue to recognize the reasonable cost of clinical nursing education on a pass-through basis, after the one year freeze expires. No changes in payment policy should be made until and unless data supporting an alternative approach are available.

Differences Between Medical and Nursing Education

It is also important to note the differences between the costs of medical and nursing education and the role of students for both professions in hospital settings. Medical education is generally more expensive with higher costs incurred by hospitals. Graduate medical students receive salaries for most of the services they provide to patients while nursing students pay tuition which includes the costs of their clinical practica.

Both nursing and medical education programs relate to each other by virtue of sharing resources and responsibilities of a teaching hospital. Thus, reduced GME Medicare payments to a hospital under a provision of law could seriously jeopardize a nursing education program with clinical placement programs in the same institution, and the effect on the nursing program would not necessarily have been considered or intended in formulating such policies.

In terms of the indirect adjustment, most studies to date have not sufficiently addressed the indirect costs of nursing education but instead have focused solely on graduate physician education. The distribution of nursing education clinical practica differs from the distribution of graduate medical education programs. Although the prospective payment system's indirect adjustment to teaching hospitals for the higher costs incurred by those institutions is meant as a proxy for all of the teaching costs incurred, data are lacking for indirect teaching costs specific to nursing--especially in smaller community hospitals that do not have a medical internship or residency program, but do have one or more affiliated nursing programs. The role of nursing and the costs of nursing education in a small community hospital may be different than in a large teaching hospital.

Therefore, we would urge that the studies undertaken by the General Accounting Office (GAO) to examine the indirect educational costs and the differences between teaching and non-teaching hospitals also take into account what the impact of these differences are on the utilization of nursing resources--both for nursing education and nursing service.

Nursing, like other health professions, is going through a period of profound change adjusting to new trends toward less hospitalization and more ambulatory and primary care. However, the responsiveness of nursing educational programs to changing consumer demands present a very different picture from those graduate medical education programs. This is basically because the demands for nursing are different than those for medicine. We would urge, therefore, separate consideration be given to both the need for nurses and the urgency and form of any government incentives under Medicare. Conclusions about what Medicare should pay for physician education in the clinical setting should be separate and distinct from policies that may be designed for nursing programs.

Supply and Demand for Nursing Care

A word of caution is necessary regarding assumptions of the physician surplus as it pertains to Medicare's reimbursement of GMEs. Statements in the Congressional Record of May 16th, in the introduction of S1158, refer to the growing physician surplus. There is not nearly so clear a consensus concerning the adequacy of the supply of registered nurses as there seems to be with respect to physicians. On the contrary, in particular specialties and in the case of practitioners prepared at advanced levels, there are serious shortages and a maldistribution of nursing personnel. This is especially true for nurses with special training in geriatrics and long term care, in highest demand by medicare beneficiaries.

With the dramatically changing health system resulting in more acutely ill hospital patients, an explosion in ambulatory health services, and a growing demand for post-acute and home care--all of which are delivered by nurses--it would be erroneous to justify reductions in Medicare's funding of nursing education on the grounds of an oversupply of nurses. In fact, there is increased demand for nursing care for Medicare beneficiaries beyond the hospital setting. We would hope that Medicare's financial support might eventually be extended to these clinical training sites outside of the acute care setting.

We recommed that whatever new Medicare policies are ultimately developed they will include innovative approaches of collaboration among a variety of professions such as nursing, medicine, psychology, physical therapy and others. Nursing is ready to work with you and your staff in promoting a full range of alternative health care delivery models that would improve care to Medicare beneficiaries; cost effective nursing models of care being one such alternative approach.

Recognizing beneficiaries' needs for care beyond the hospital setting, we recommend your adding to the bill a separate section (d) regarding additional studies. These studies would report on methods by which Medicare could finance its share of nursing educational costs in ways that facilitate adjustments in training sites and curriculum to reflect changes in health care practice patterns and the particular needs of the elderly.

Changing Trends in Nursing Education

Before any policy changes can be implemented regarding nursing education and Medicare, changing trends in nursing education since Medicare was enacted 20 years ago must be taken into account. At that time, it was logical that the majority of funding was allocated to hospital based diploma programs because they comprised the largest number of nursing programs and students. This trend of allocating the majority of Medicare's funds for nursing education to diploma programs has continued today despite changes in the locus of nursing education.

Since 1965 the locus of nursing education has increasingly shifted from hospital-based programs to institutions of higher education. The number of diploma programs has dropped more than 50%--from 813 to 281, while the number of basic nursing programs located in institutions of higher education has increased from 369 to 1,185 (421 baccalaureate and 764 associate degree programs).

The demand for college-based nursing education can also be attributed to the growing number of diploma graduates who are returning to school for baccalaureate and advanced degrees in nursing. Over the past 20 years, there has been a large increase in the number of master's nursing programs (56 in 1965 compared with 154 in 1983).

With the huge increase in the number of students in nursing programs located in institutions of higher education, Medicare dollars do not necessarily reflect the developments in nursing education. An understanding not only of where current funds are being spent, but also of how nursing education has changed must be taken into consideration in assuming equity for Medicare's payments for nursing education and in formulating any future policies.

Conclusion

Given these factors, the Nursing Tri-Council strongly supports the recommendations for the future study on nursing educational activities under Medicare, as specified in S1158. Our members and staff welcome the opportunity to work with you and the Department in this regard.

We are concerned that changes aimed specifically at restructuring reimbursement for medical education under Medicare not inadvertantly affect nursing education or practice. This is especially true insofar as Medicare beneficiaries' needs for nursing care are separate from their needs for medical care. The systems of practice and education for the two professions are structurally very different.

And finally, we recommend that any future changes in Medicare's policies towards financing nursing education be implemented only after careful analysis of data collected, and that such changes take account of recent trends in nursing education.

We thank you for the opportunity to present our views will gladly answer any questions.

STATEMENT OF SHARON A. SCANLON, GEORGETOWN UNIVERSITY MEDICAL SCHOOL, WASHINGTON, DC, ON BEHALF OF THE AMERICAN MEDICAL STUDENT ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY HELEN BURSTIN, NATIONAL PRESIDENT OF THE AMSA

Ms. SCANLON. Thank you.

My name is Sharon Scanlon, and I am a fourth-year student at Georgetown University School of Medicine. I am testifying today on behalf of the American Medical Student Association, an independent organization of over 30,000 medical schools at 140 allopathic and osteopathic medical schools throughout the United States. Accompanying me is Helen Burstin, president of the American Medical Student Association and a third-year student at State University of New York at Upstate Medical Center.

As medical students, we have a vested interest in our postgraduate training. Residency training has become an essential prerequisite to entry in the practice of medicine. Every U.S. medical school graduate must have the opportunity to complete their training in approved GME education programs and be assured that the training programs and the quality of their training programs remain stable throughout their training.

As physicians in training, we are concerned about the future of our health care system. We want to ensure that we are training an adequate number of physicians and that those physicians enter the specialty in geographic areas where they are needed most.

Over the past 20 years, due to successful Federal initiatives, we have doubled the number of students graduating from our medical schools. Yet there are few instances where those enter the primary care specialties in order to practice in underserved areas. On the contrary, we have medical students, not just myself, graduating and $80,000 in debt, and looking at a reimbursement system that disproportionately rewards those who enter the medical and surgical subspecialties and practice in areas where patients can afford to pay for their services.

We believe that all of these issues—medical class size, financing of undergraduate and graduate med ed, physician reimbursement, and the specialty and geographic distribution of physicians needs to be addressed. The proposal set forth in S. 1158 is a positive first step toward addressing these issues. It does have a number of strengths which deserve to be mentioned:

First, it guarantees the continued commitment of the Federal Government to graduate medical education. Using patient care revenues provides residency programs with a predictable financial source and provides residents the assurance needed that the training programs and the quality of those programs will remain stable throughout their training.

Because residents do spend a significant proportion of their time providing direct patient care, we believe it is appropriate to use patient care revenues to reimburse house staffs and that Medicare should continue to pay its proportionate share.

We will, of course, as others before me pointed out, need to continue a certain number of graduate fellowship programs; however, this still fails to address how these programs will be financed. We believe that this is an important issue and one that needs to be resolved prior to any change in the financing of graduate medical education. We fear that without an explicit policy regarding this funding, that possibly the residents in these fellowship programs would start billing the patients directly, possibly under part B of Medicare, and this would result in an increase in costs to the Medicare Program.

In our written testimony we offered one method of addressing this, and this would be through a special project or categorical grant for specific training programs. The number of physicians funded could be determined every few years and based on the manpower needs of that specialty.

The proposal before us today supports the continuing funding of residency training for Americans but not for alien graduates of foreign medical schools. It is the position of the American Medical Student Association that the United States should fulfill its medical manpower needs through the education of its own citizens for the practice of medicine, and that we should stop the ethically questionable practice of recruiting physicians from other countries to fill our manpower needs. Using AFMG's to fill residency positions considered undesirable by graduates of LCME-approved medical schools provides the patients served by those residents with a lesser quality of health care and provides residents with a very limited amount of exposure to our health care system. However, we do strongly believe that any funding for the training of these programs which, if it is to be eliminated, should be done very slowly—and in our written testimony, we suggested that this be done over a 5-year period.

The fact is that foreign medical graduates are providing necessary patient care services in many of the inner-city hospitals and small rural community hospitals. The sudden elimination of those funds would be disastrous to the hospitals and the patients served in those areas.

As for the training of American graduates in foreign medical schools, we are concerned about the quality of the education they are receiving. We have all heard anecdotal reports of insufficient libraries, facilities, inadequate laboratories, unqualified faculty, or inadequate clinical exposure. It is our belief that at the very least these reports should be investigated more fully and that these schools should be monitored and accredited using standards comparable to those utilized within the United States.

This completes our oral statement. We thank you for the opportunity to present our views and welcome any questions or comments you may have.

[Ms. Scanlon's written testimony follows:]

Testimony of the
American Medical Student Association
on
Graduate Medical Education

Mr. Chairman and Members of the Committee:

My name is Sharon A. Scanlon, and I am a fourth year medical student at Georgetown University medical school. I am testifying today on behalf of the American Medical Student Association. Accompanying me is Helen Burstin, President of the American Medical Student Association and a third year student at State University of New York at Upstate Medical Center.

The American Medical Student Association (AMSA) is a national organization of over 30,000 medical students at 140 allopathic and osteopathic medical schools throughout the United States. AMSA is an independent organization of physicians-in-training committed to the improvement of medical education and health care delivery so that we, as practicing physicians, may better meet the health care needs of all the nation's people.

The American Medical Student Association is very interested in the problems of health manpower. In the past, we have supported federal efforts to increase the number of graduating physicians and a federal program that placed physicians in underserved areas. Presently, the nation is faced with a dramatic increase in the number of graduating physicians but no mechanism by which to ensure that they enter those medical specialties that will be needed in the near future. We commend your efforts to address this problem and would like to share with the subcommittee our concerns and ideas about the future financing of graduate medical education.

The Role of the Federal Government in Medical Education

During the late 1950s and early 1960s, several government and private reports predicted an impending shortage of physicians. The enactment of Medicare and Medicaid in 1965 increased financial access to health care services for the poor and the elderly and resulted in an increase in demand for physician services. It was predicted that an increase in the aggregate number of physicians would be needed to meet this demand. Congress responded to this predicted shortage by enacting the Health Professions Educational Assistance Act of 1965, which provided funds for construction of new medical schools or expansion of existing ones, as well as low interest loans to medical students. This was followed by the Health Profession Education Act of 1965, which added federal scholarships and capitation grants.

The incentives for medical schools to expand were continued through 1981 and were very successful in increasing the physician training capacity of U.S. medical schools. They resulted in a growth from 87 medical schools graduating 7,300 physicians in 1963 to 126 schools graduating 16,558 physicians in 1984.

During the early 1970s, the focus of attention changed from the number of physicians to the distribution of physicians. The establishment of the National Health Service Corps (NHSC) Scholarship program and the Area Health Education Centers (AHECs) marked the beginning of federal initiatives designed to address this problem of maldistribution of physicians. Although these programs started out small, they took on major significance in the mid 1970s. In 1976, the largest and broadest of Health Professions Legislation was passed (PL-94-484). Many strategies were implemented to improve the geographic and specialty distribution of physicians. This bill provided assistance for the establishment of family practice and primary care residency training programs, significant expansion of the NHSC Scholarship program and a broadening of the definition of underserved areas to include more urban areas, and an expansion of the Area Health Education Center program.

These programs have been successful in placing health care practitioners in underserved areas and in increasing the number of primary care physicians. The National Health Service Corps program has been very successful in making health care services more accessible in rural and inner city areas. Government support for primary care medicine is largely responsible for the growth and development of this specialty.

In 1980, several reports began to change the way that health manpower needs were viewed. The report of the Graduate Medical National Advisory Committee (GMNAC) stated that there would be a surplus of U.S. physicians by 1990, and a study by the Rand Corporation suggested that physicians were beginning to diffuse into previously underserved areas due to market forces created by a greatly expanded supply of physicians. These "facts" about the surplus of physicians and the diffusion into shortage areas were quickly incorporated as the basis of health manpower policy:

- Capitation funds to medical schools were totally eliminated in FY82 (causing medical school tuitions to skyrocket).
- Federal supplemental payments to the Health Professions Student Loan revolving funds ($16.5 million in FY1980) were eliminated in FY85.
- National Health Service Corps Scholarships ($85.0 million in 1980 and $2.3 million in 1985) and Exceptional Financial Need Scholarships ($10.0 million in 1980 and $7.0 million in 1985) have been drastically cut and are targeted for elimination in 1986.
- The Administration is now proposing reductions in Medicare reimbursement for the direct and indirect costs of graduate medical education.

This new era of health professions assistance has been characterized by a reluctance on the part of the federal government to subsidize medical education, because "there are already too many physicians." There appears to be a suspicion that the provision of Federally subsidized aid for medical education will increase the number of physicians. This simply is not the case. Support for undergraduate medical education does not influence the number of students obtaining a medical education, rather it determines who is able to afford a medical education. Federal support for the direct costs of graduate medical education is actually remibursement for patient care services. Budgetary freezes or cuts in graduate medical education would, again, not influence the number of doctors but could have a very deleterious effect on residency training programs and on patient care.

These changes in federal support for undergraduate medical education have resulted in skyrocketing tuitions, decreasing availability of low interest loans and scholarships and an increasing dependence on high interest loan programs. The average annual cost of a medical education at private schools is currently $19,200 and at public schools $10,750 for state residents. As the availability of low interest loans has declined, medical students have been forced to rely on what was originally designed to be the loan of last resort--the Health Education Assistance Loan. This has resulted in a dramatic increase in medical student indebtedness. According to the AAMC Graduation Survey, mean debt has almost doubled ($15,663 to $26,496) in the last five years, and the fraction of students whose debt exceeds $50,000 has more than quintupled -- 1.5% to 8.1%.

The American Medical Student Association is very concerned about the potential impact of medical student indebtedness on the future specialty and geographic distribution of physicians. As medical students graduate with astronomical debts, they will be forced to enter the more lucrative subspecialties as opposed to primary care medicine.

All of these issues--medical class size, the financing of undergraduate and graduate education, physician reimbursement, and the specialty and geographic distribution of physicians are closely intertwined. There are no simple answers to these problems, but a few things seem very clear. One, the federal government is deeply involved in health manpower planning and has an important role to play. Two, we are at a crucial juncture in our health manpower planning. We now have an adequate number of physicians graduating, but there are few, if any, incentives for them to enter the medical specialties where they are needed most. It seems entirely appropriate that the federal government continue to provide the incentives and regulations needed to influence the specialty distribution and geographic distribution of physicians.

The proposal set for in S. 1158 represents a first step in the restructuring of our system of graduate medical education. The bill has a number of strengths which deserve to be highlighted.

First, it guarantees the continued commitment of the federal government to graduate medical education. Under this bill, Medicare would continue to pay its proportionate share of the costs associated with residency training. This predictable financial source would allow residents the assurance needed that the training program and the quality of the training program they are participating in will remain stable through their residency training.

Second, the enactment of this proposal would result in an increase in the proportion of physicians trained in primary care. It would put a halt to the training of an excess number of medical and surgical subspecialties.

It is generally agreed that an oversupply of subspecialists will only serve to increase the cost of health care and contribute further to the geographic maldistribution of physicians. An expanded pool of primary care practitioners, on the other hand, is more likely to result in better access to health care services for all Americans.

We will, of course, need to continue a certain number of graduate fellowship programs. However, this bill fails to address how these programs will be funded. This is an important issue and one that needs to be resolved prior to any change in the financing of graduate medical education. Without an explicit policy regarding the funding of graduate fellowship programs, the funding source may simply shift from Medicare part A to Medicare part B without any savings to the Medicare program or any change in the specialty distribution of physicians.

One method of financing fellowship training is through special project or categorical grants for specific training programs. The number of positions funded could be determined every two to three years and based on the manpower needs of that specialty. For example, it is anticipated that an increased number of Geriatricians will be needed to care for our aging population. Graduate fellowship programs will be needed to train physicians in the special medical problems of the elderly. Federal funding would then be targeted for fellowship programs in Geriatrics or other medical or surgical subspecialties determined to be needed in our communities. This method of financing would be less costly than the current open-ended reimbursement system and would be more responsive to the Nation's health care needs.

The proposal embodied in S. 1158 for the limited financing of residency training, together with federal grants for graduate fellowship training, would ensure a large number of physicians trained in the primary care specialties and a small, highly trained cadre of subspecialists.

The Funding of Graduate Medical Education through Patient Care Revenues

Mr. Chairman, medical education is a very long and demanding process. After a minimum of four years of undergraduate college and a competitive admissions process, approximately half of the medical school applicants enter United States LCME approved medical schools. The first two years of medical school consist of classes and laboratory work in the basic sciences. During the next two years, medical students are introduced to the clinical sciences. Here, they learn by working closely with physicians and residents in the treatment and management of patients.

Residency training is where the physician gains most of his or her "hands on" experience. The resident physician learns by caring for patients under various degrees of supervision by licensed physicians. The resident participates in every aspect of patient care, including the diagnoses, treatment and management of numerous patients. The resident works long hours with little vacation time. It is not uncommon for a first year resident to work 80-100 hours per week and have 1-2 days off per month. Any resident will testify to the fact that a significant proportion of that time is spent providing direct patient care.

The complex relationship between medical training and patient care is not easily defined and will not be elucidated by further studies and research into this area. Medicare accounting methods do not and can not permit a precise separation of the costs between education and patient care. This is because residents care for patients while being trained. Therefore, it seems entirely appropriate that we continue to use patient care revenues to pay for housestaff salaries and the related direct costs of graduate medical education and that Medicare continue to pay its proportionate share of these costs.

The Residency Training of Foreign Medical Graduates

American policy regarding the training of foreign medical graduates has been one of inconsistencies formulated more by our own self intersts and by constituency pressure from Americans studying in foreign medical schools than by clear, sound and ethical principles.

During the 1960s and 1970s, when reports predicted a shortage of physicians, the United States recruited foreign physicians by giving immigration preference to foreign physicians certified by the Educational Commission for Foreign Medical Graduates (ECFMG). The number of foreign physicians entering to train and practice medicine in this country increased steadily until the 1970s. These physicians did help to solve our health manpower shortage but created a "brain drain" from other countries.

In 1976, during the midst of an increase in the number of U.S. medical school graduates, Congress revoked the preferential professional inducements provided in the earlier amended Immigration and Nationality Act, and in passing PS 94-484, declared that a shortage of physicians no longer existed and called for regulations that would limit the period alien foreign medical graduates who seek clinical training could remain in the United States.

Then, another problem arose. Along with the increasing output of U.S. medical schools and the now decreased but steady entrance of alien foreign medical graduates into the United States, appeared, in increasing numbers, American citizens who had obtained medical degrees from foreign medical schools and who desired to return to the United States for residency training and to practice medicine.

Even with the increased size and number of U.S. medical schools, many applicants were unable to obtain admission to U.S. medical schools and chose to pursue their medical education in Europe or, more recently, in Mexico or the "off shore" medical schools in the Caribbean. In contrast to U.S. medical schools, these schools are not monitored by either national or international accrediting agencies, and the quality of the education provided has come into question on numerous occasions.

The proposal before us today supports the continued funding of residency training for American graduates of foreign medical schools. Mr. Chairman, although we can not provide definitive evaluations of the medical education obtained in these foreign schools, we have all heard numerous anecdotal reports of insufficient library facilities, absent or inadequate laboratory experience, unqualified faculty in a number of the basic sciences and inadequate clinical exposure. It is our belief that, at the very least, these reports should be investigated more fully and that these schools should be monitored and accredited using standards comparable to those utilized within the United States.

Most foreign medical graduates (FMGs), especially alien FMGs, obtain the residency positions considered undesirable by American graduates. Many are serving in inner city hospitals and rural community hospitals caring for our poor and underserved. This practice continues an intellectual drain of physicians from other countries and the ethically questionable practice of recruiting physicians from other countries to fill our manpower needs. In addition, we are providing alein foreign medical graduates a disservice by providing them with a very limited and narrow exposure to our health care system.

We propose the continued training of a small number of alien foreign medical graduates, under stricter visa requirements, and at centers that would provide them with a broader clinical training. This would make much more sense, both in terms of health manpower and in terms of international health. These foreign medical graduates would then be better prepared to return to their respective countries with the knowledge and expertise necessary to improve health care and medical education in their countries. The funding could come from the government of the parent country and/or from the general revenues of the U.S. government, not from Medicare dollars.

The elimination of funds for the training of foreign medical graduates must be phased in slowly in order to allow the hospitals an opportunity to develop a plan for attracting American graduates or replacing resident physicians with other health care personnel. In many of our inner city hospitals and small rural community hospitals, foreign medical graduates are providing necessary patient care services. The sudden elimination of funding for resident physicians would be disasterous for the hospitals, many of which are already under compensated for their care of the indigent.

In conclusion, we agree that Medicare should no longer support the residency training of non-U.S. citizens who are graduates of foreign medical schools. However, we recommend that this policy be phased in over a five year period. Each year, beginning one year after the enactment of this proposal, the number of residency positions filled by graduates of foreign medical schools and reimbursed by Medicare would decrease by 25%. This would allow adequate time for the hospitals to find other means of filling health care personnel needs. In addition, we encourage the federal government and the medical profession to explore methods of placing and funding a limited number of alien foreign medical graduates in residency programs of high caliber.

Finally, if we are to continue to fund the residency training of American graduates for foreign medical schools, then these schools should be monitored and accredited using standards comparable to those utilized within the United States.

Thank you for the opportunity to present our views.

Senator DURENBERGER. Mr. Capone, you state that many of the professions you represent are currently in short supply. It was my impression from the latest projections of the Bureau that in most areas there is at least a potential surplus.

Can you tell us which of the professions you represent are currently in a shortage situation and what the impact of those shortages is?

Mr. CAPONE. Yes, sir; several.

The podiatric profession is one where there is a shortage. There is one podiatrist right now for every 27,000 Americans, and roughly about 1,400 podiatric-shortage areas.

Other health professions include public health where a number of shortages have been identified by studies that I am sure can be provided. I believe one of the studies was the Surgeon General's report that identified shortages, or at least the critical shortages for environmental health specialists, epidemiologists, biostatisticians.

Another area would be pharmacy. Enrollments have been down for a number of years in pharmacy schools, and I think they are just now catching up. Still, there is a shortage.

In osteopathic medicine, I believe approximately 80 percent of osteopathic physicians are primary-care providers.

As we know from the Graduate Medical Education National Advisory, a committee report in 1980, this was an area that I believe was identified as the largest shortage area in the country.

Now, lest I have forgotten any other health professions, we could provide that for the record.

Senator DURENBERGER. I was wondering, and maybe I should have phrased it a little differently, about the degree to which the economics in certain parts of the medical profession make those more attractive than others. I mean, you talked about the environmental area and some of the other preventive areas where you may come up short. In part is that because other areas are more attractive and have been more attractive in this country in which to practice your inclination to the health profession? The point is, are we just not paying well enough in certain of those professions as a society? Is that part of the problem?

Mr. CAPONE. Yes, I would agree with that, that there is a preference for some disciplines because of the monetary aspect.

As far as all of the health professions, it would be difficult, in terms of the income levels for these professions, for me to provide a statement to cover all of them. I am really not sure I am in a position to be able to address a question for all of the health professions in that regard.

Senator DURENBERGER. Dean Fahy, let me ask you to help me with some projections on the nursing supply. I spoke to 237 graduates the other night at St. Mary's Junior College, and from their comments they didn't all sound like they were walking right out into a job.

Dean FAHY. That doesn't surprise me, Senator. I think dealing with numbers in the health professions is very, very tricky, a very tricky business. In Minneapolis and St. Paul just this last year we have been undergoing a rather peculiar employment pattern, and for the 2 years 1983 and 1984 for many of our graduates, upon graduation and giving them their diploma and asking if they had a job, one did it with fear and trembling. And then last year, of course, we had a major strike, the only one of its kind in the country, and that's what we are known for, I guess. We were fearful that there would be no job openings at the beginning levels for 5 years. Those were the rumors floating around the Twin Cities.

In March of this year, 51 of my graduates graduated on or about March 12, and for 30 of them, all of a sudden the market in Minneapolis/St. Paul opened up, and the young graduate not only got employment but got the job that they wanted in Abbot-Northwestern, in our university hospitals, in St. Paul Ramsey, North Memorial, all of the local hospitals in the Twin Cities. So—the numbers game.

We have of course here the fourth report to Congress on nursing personnel, which was conducted by HHS. It projects by 1990 there will be a need for 824,000 nurses prepared at the baccalaureate level. The actual supply is estimated to be at 380,000. And we will need 358 nurses prepared at the masters and doctoral level, while the actual supply will be about 113,000.

So when you talk about us being in oversupply, money, Senator, is certainly not the motivation for pursuing nursing; it has to be something other than that.

Now, one gets very, very skeptical in terms of probably in certain areas of the country they are oversupplied and in other areas, in rural out-State Minnesota, they are desperately searching for our nurse practitioners, our nurse midwives; and we have tried to impact on rural health care that State, but it is not easy to do. So I think in certain areas they probably are; in others there are very few.

Senator Durenberger. Ms. Scanlon, I think you indicated that you are a fourth year medical student. In your experience and that of your fellow residents, if hospitals were to reduce the size of their teaching programs in response to the proposed reductions in payment under the Medicare Program, what is your expectation about the likely outcome? I would like you to in particular, if you can, address your expectations regarding the cost increase under part B of the Medicare Program as physicians or residents begin billing for services that were formerly provided by the residents.

Ms. Scanlon. To your first question, if they decrease the size of the residency programs, I would have to say that already it is very competitive and is becoming more competitive to obtain a residency position, especially in a certain geographical area or in a certain specialty. So I see it as becoming even more competitive, and I think this would have certain effects on our medical education that I wouldn't want to see—that increase in the competitiveness.

Also, I would assume that you are saying there would still be enough positions to meet the requirements of those graduating from medical schools, that there would still be at least a 1-to-1 ratio. I don't see that you are saying it would fall below that. Obviously, medical school graduates wouldn't even be able to practice without residency training.

You asked about the cost if they started billing under part B. I mean, I don't think any of us know that. I do think it would be more expensive, though, especially for a fourth or fifth year surgical resident or actually one of the subspecialists in medicine who is spending a lot of time with patients and providing a lot of services. If they started billing directly, it would increase the costs.

Senator **Durenberger**. Well, that is our expectation around here without knowing, and that is why I asked you the question, if it is your anticipation that we would be increasing the costs in that area.

Well, gentlemen and women, I appreciate your testimony. You have been very helpful to us here this morning.

We will move now to our final panel, which consists of Mr. Richard Berman, executive vice president of New York University Medical Center in New York, on behalf of the American Hospital Association; Dr. William Minogue, the president of the Association for Hospital Medical Education; and Mr. Mark Russell, the senior vice president and chief operating officer of Kennedy Memorial Hospitals, University Medical Center, Stratford, NJ, on behalf of the American Osteopathic Hospital Association, accompanied by Martin A. Wall, vice president of the AOHA.

As you begin I will indicate what I have indicated in the past, and that is that the statements which you have so thoughtfully provided us in advance of your testimony will be made part of the record in full, together with any amplifying comments you may want to make for some short period of time while the record remains open, and we will ask each of you to summarize your statements in 5 minutes, starting with Mr. Berman.

STATEMENT OF RICHARD BERMAN, EXECUTIVE VICE PRESIDENT, NEW YORK UNIVERSITY MEDICAL CENTER, NEW YORK, NY, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. **Berman**. Thank you, Senator.

On behalf of the American Hospital Association, I want to thank you and your staff, because this issue is something that you have dug into, and it is a tough issue. Both in terms of substance and style, S. 1158 is much stronger and better than the administration's inappropriate regulatory action.

Let me speak to two or three of the issues quickly, since you do have full testimony on the record:

In terms of the freeze, the AHA recognizes the need for budget constraints in the Medicare Program, and so we do support that.

I would suggest that you consider an exception process to the freeze left up to the Secretary or some appropriate body, because I think we are beginning to see some consolidation of some residencies. On the other hand, if you have a hospital in a rural area that may be now an appropriate site for some general practice residency or family practice residency, I am not sure you want to discourage that or just lock in the current system. But again, on the whole, I think that is an appropriate and reasonable way to go.

In terms of the length of time, obviously you have heard the discussions about more and less. It is clearly a much better option and seems to go in the direction that you want to head much better than an arbitrary 1, 2, 3, 4, or 5 years across the board.

While we are supporting this on the issue of the direct payment, it seems noteworthy to highlight that this is probably inversely related to the indirect costs.

I think the bill will also have to address physicians in training that are beyond the limit. You have just now disqualified them for part A. which would make them eligible for part B. If it is costs that you are concerned about, I am not sure on the surgical specialties that if you allow them to charge for part B that you will in fact really save money.

I think if you don't provide them that option, certain institutions which may be ideal training programs in terms of burn care, microsurgery, et cetera, will be unable to fund those sites, and I think you are going to end up costing yourselves more and perhaps not having the impact that we are looking for.

The one issue that obviously is of most concern to hospitals in general is the foreign medical graduate issue. On the issue of quality, we have relied on the residency review committees and the educational and professional bodies to tell us which are quality and not quality issues. The foreign medical graduate in an approved residency program has been both an educational component and a patient care component. It falls disproportionately in both the rural areas and some of our inner cities. It falls disproportionately, perhaps, in some of those areas of less desirable places to live and may not be dependent as directly on the quality of the educational program.

If it is the intent, based on what you have heard, to reduce or eliminate the foreign medical graduates, it is not something that will pass evenly through all hospitals, and it therefore should be, I think, more targeted in its exception process and in its phasing down.

Again, we want to thank you for your interest and willingness to tough it out with these difficult issues.

Senator **DURENBERGER**. Very good.

Dr. Minogue.

[Mr. Berman's written testimony follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE OF THE UNITED STATES SENATE ON S.1158, ON MEDICARE PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS

June 3, 1985

INTRODUCTION

Mr. Chairman, I am Richard Berman, executive vice president of New York University Medical Center in New York City. I am pleased to be here on behalf of the American Hospital Association (AHA), to address S.1158, a measure on Medicare direct graduate medical education costs that was introduced May 16 by Sen. Robert Dole, for himself, Sen. David Durenberger, and Sen. Lloyd Bentsen. The AHA represents over 6,100 member hospitals and health care institutions, as well as more than 38,000 personal members.

The Association is concerned about the financing of medical education, in terms of its implications for physician manpower policy, graduate medical education programs, and patient care, especially referral services. The Association believes that efforts to change the financing system should not only take into account these factors but also changing financing characteristics of the hospital industry caused by the adoption of Medicare prospective pricing and comparable private sector innovations. The

Association believes that the provisions of S.1158--a one-year freeze on direct medical education costs recognized as "reasonable" by Medicare; a limitation on the number of years of graduate medical education for costs recognized as allowable by Medicare; and a restriction on costs associated with training of foreign medical graduates that are recognized by Medicare--raise significant issues for hospitals involved in graduate medical education.

CONNECTION BETWEEN MEDICAL EDUCATION AND THE MEDICARE PROGRAM

Decisions on the financing of graduate medical education have influenced and continue to affect the provision of medical care to patients, including those in the Medicare program. Historically, such decisions have respected and reflected the fundamental unity of medical education and medical practice in this nation. Because of this unity, consideration of proposals to reform the graduate medical education financing system should be cautious and their adoption incremental, due to the implications of changes on both education and care.

The most obvious implication is the supply of adequately trained physicians, because the financing mechanism offers a powerful tool for shaping the number and specialty distribution of physicians. However, the actual number and distribution are determined by many factors, most of which occur outside the system, in a highly pluralistic, decentralized process that involves hospitals, medical schools, state legislatures, and private third-party payers, as well as resident physicians. This is not to deny the importance of Medicare policy, which at best sets a tone and direction for other payers rather than pursues highly specific manpower planning goals.

A second implication of changes in graduate medical education financing concerns the size and duration, as well as the content and quality, of graduate medical education programs. The financing system influences such aspects as the amount of student interaction with faculty, the maintenance of fellowships which contribute to the quality of the education available to more junior house staff, and the availability of diverse, clinically rich experiences for house staff.

A final implication involves patient care, particularly in the availability of referral services. Most teaching hospitals serve, to some degree, as referral centers, so that their patients tend to be more seriously ill and require more costly services than patients admitted to nonteaching hospitals. Moreover, teaching hospitals tend to provide disproportionate amounts of care to the poor and uninsured. Because recent and ongoing changes in the system of payment for patient care have increased significantly the financial stress experienced by these hospitals, changes in medical education financing could contribute to the strain, jeopardizing the ability of teaching hospitals to continue the essential role they have played in local health delivery systems.

It is clear that changes are inevitable in the financing system for graduate medical education. Indeed, they already are occurring. Due to the close connection between medical education and medical care, such changes--considered cautiously and implemented incrementally--should take into account the effects of reforms on the number and distribution of physicians, the aspects of medical education programs, and the provision of patient care.

It also is clear that the current financing system rapidly is losing its viability. The future education of physicians and other health professionals is a shared responsibility. While Medicare policymakers continue to recognize the importance of graduate medical education and the program's obligation to bear a fair share of its costs, private sector decisionmakers are less willing to see their responsibility. In addition, as competition among health insurers increases, those in the private sector may be less able to participate in the costs of graduate medical education. The formidable challenge before the public and private sectors is to create a financing system that ably ensures a supply of well trained physicians and health professionals while equitably distributing the costs of developing that supply.

IMPACT OF MEDICARE PROSPECTIVE PRICING

Proposals like S.1158 that modify the way in which Medicare pays for costs associated with graduate medical education must be evaluated in the context created by current arrangements for financing patient services. The adoption of Medicare prospective pricing, as well as comparable private sector innovations, is changing radically the characteristics of the hospital industry.

The response of hospitals to the incentives of prospective pricing has been both strong and positive. It also has been varied. While it is impossible to distinguish between Medicare and non-Medicare costs, the overall data for the industry provides clear evidence that economic incentives are the most effective way of containing costs. During calendar year 1984, total hospital expenses rose 4.5 percent, less than one-third the rate of increase two years ago (15.8 percent) and less than one-half the 1983 rate of increase (10.2 percent). Inpatient expenses in 1984 increased even more slowly, 3.2 percent.

The dramatic slowing of the rate of increase in costs is largely the result of three factors. The first factor is a sharp decline in admissions for both the over-65 and under-65 populations. Total admissions declined 4.0 percent in 1984, after experiencing no change in 1982 and declining 0.5 percent in 1983. Admissions of patients under 65 years of age declined the most sharply in 1984: 4.5 percent. The change in admissions of patients over the age of 65 also was dramatic. After rising steadily for more than a decade, over-65 admissions declined 2.9 percent in 1984.

The second factor contributing to the slower increase in hospital expenses in 1984 was a continued decline in average length of stay. While considerable attention has been given recently to the decline in length of stay for Medicare patients, it is important to realize that length of stay declined for both over-65 and under-65 patients and that historically the trend has been toward shorter stays.

The third factor responsible for slower growth of expenses is a reduction in hospital employment made possible by a lower census. While hospitals employed fewer people in 1984 than in 1983, the number of staff hours per patient actually increased, indicating a continuing concern with meeting the medical needs of patients.

The strong response of hospitals to prospective pricing does not mean that the implementation of the system has been or will be without problems. While data on the first year's impact of prospective pricing are not available from the Department of Health and Human Services' Health Care Financing Administration (HCFA), the AHA and the Congressional Budget Office have made intensive use of the data that are available to anticipate the effects of the system. The AHA is eager to update this analysis, using more current information once the data are made available by HCFA. Although the data on which the following findings are based are admittedly not as current as would be desirable, they do indicate the general pattern of effects to anticipate.

The most significant features of the prospective pricing system for any discussion of medical education financing are the transition to national rates and the impact of the indirect medical education adjustment. The AHA has identified some significant, and troubling, patterns which suggest that the current method of setting prices and the present system of diagnosis-related groups may be systematically biased against certain groups of hospitals.

PROVISIONS OF S.1158

S.1158, introduced by Sen. Dole for himself and Sens. Durenberger and Bentsen, would modify the methods used by Medicare to pay for the costs of graduate medical education. The proposal has three key parts:

- a one-year freeze on direct medical education costs recognized as "reasonable" by Medicare;

- a limitation on the number of years of graduate medical education for costs recognized as allowable by Medicare; and

- a restriction on costs associated with training of foreign medical graduates recognized by Medicare.

While the proposals appropriately recognize the limited ability of Medicare to shape national manpower policy, they raise several significant issues for hospitals involved in graduate medical education.

One-Year Freeze

The AHA, concerned about the size of the federal budget deficit, recognizes the obligation of hospitals to participate in a deficit reduction solution. The Association views any freeze on hospital payments as part of an overall, balanced approach to deficit reduction--an approach achieved by legislation, not by regulation in the absence of congressional action. In this respect, it is important to note that HCFA, in proposed regulations printed May 21 in the Federal Register, announced a regulatory "freeze" on graduate medical education payments. The proposed "freeze" actually would roll back payments to the level prevailing in Fiscal Year 1984. Such an approach, by arbitrarily restricting payment and increasing uncertainty about the long-term stability of the financing system, is counterproductive.

A freeze, if it is to be equitable, must be uniform. It also must be temporary; unfortunately, temporary freezes tend to become permanent, particularly when they affect a relatively small group. It is critical that any freeze on graduate medical education payments be viewed in the context of an overall budget freeze, and not as an interim policy that will continue until a longer-term system for financing graduate medical education can be developed.

The provision in S.1158 fails to recognize the contribution which a freeze may make to the financial stress placed on teaching hospitals by the prospective pricing system. While many hospitals may be able to cope with a temporary freeze, others may not. To address this problem, an exceptions process should be considered for those hospitals that may experience substantial deficits under the proposed payment policy.

Limitation on the Allowable Length-of-Residency Training

The provision in S.1158 would limit the allowable length of training recognized by the Medicare program to the lesser of five years or the number of years required to achieve board eligibility. This approach is more equitable than a limit on the number of years of training that would not take into account board eligibility requirements. It also is administratively simpler than proposals that would limit the number of positions whose costs would be recognized as allowable. Most importantly, the approach would avoid the problem of "graduating" only partially trained physicians in specialties requiring more than the maximum allowable years of education.

The proposed limitations do, however, create some special problems. Postgraduate medical education is important in the training of physicians who will provide tertiary referral services. It also is important in the training of physicians in "primary" specialties, because postgraduate fellows and residents often provide consultation for more junior house staff. While it may not be necessary to fund fellowships and other forms of postgraduate medical education in the same way as graduate medical education positions, it is essential to develop an alternative source of funding. If these costs are not funded explicitly, Medicare Part B costs may increase, the availability of tertiary referral services may decline, and/or the quality of educational programs may deteriorate. To avoid such consequences, it will be necessary to address the issue of postgraduate medical education directly, either through the Medicare program or through the creation of an alternative, independent financing mechanism.

Restriction of Funding
for Foreign Medical Graduates

S.1158 would restrict the availability of funding for residency positions filled by graduates of foreign medical schools. Funding would be available only for those positions filled by graduates of medical schools located in the United States or Canada, or who are United States citizens. Arguments can be made on both sides of this issue.

One argument to justify the proposed restriction is that foreign medical graduates no longer are needed to make up for a shortage of physicians, as was the case in the early 1970s. Another argument is the impact of current policies on the physician supply of developing nations. While most graduates of foreign medical schools choose to remain in this country as citizens, others return to their homelands. It would be unfortunate to deny the opportunity to train in the United States to such physicians. The proposed policy also could result in a longer-term loss to citizens of the United States. Many leading medical school faculty are graduates of foreign medical schools who came to the United States to complete their medical training.

Moreover, some hospitals are heavily dependent on foreign medical graduates. Often these hospitals serve populations that otherwise would be without access to medical care. Moreover, their teaching programs help them recruit attending staff. Although the proposed policy would allow those foreign medical graduates currently enrolled in residency training to complete their programs, it may be difficult for the hospitals operating those programs to recruit rapidly United States- or Canadian-trained physicians to fill their available residency slots.

A fundamental question, one requiring more study and discussion, is whether efforts to limit entry should be tied to the qualifications--rather than to the nationalities--of the individual physicians applying for positions in residency programs. Another question is how entry can be limited without disrupting either educational or patient care programs. These questions are significant, both within and without the framework of Medicare medical education payments, and should be included in the dialogue on the exclusion provision.

CONCLUSION

The AHA appreciates this opportunity to comment on direct medical education financing, generally on the connection between medical education and Medicare, as well as the impact of Medicare prospective pricing, and particularly on the provisions in S.1158. As the Subcommittee considers this measure and exercises oversight over the proposed medical education regulations in the May 21 Federal Register, the AHA offers its assistance in the development of a fair and equitable policy for such financing.

STATEMENT OF WILLIAM F. MINOGUE, M.D., PRESIDENT, ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION, WASHINGTON, DC

Dr. MINOGUE. Mr. Chairman, I represent the community teaching hospitals. There are about 1,000 such hospitals overall, and they range between 200 and 1,500 beds. The smallest may be in a rural setting and have only family practice residencies; others, such as Methodist Hospital in Indianapolis, the Ford Hospital, the Cleveland Clinic, and the Hartford Hospital are in large cities and are full spectrum medical centers.

We train approximately 60 percent of all residents in the country, 75 percent of primary care residents, and virtually all family practice residents. The mission and emphasis of these hospitals is patient care, followed by education. Research is, for the most part, clinical in nature, and we tend to have fewer subspecialty training fellowships.

On behalf of my association I wish to thank you for stimulating the academic and hospital communities to review what we are doing in medical education, and to work constructively with you to contain some of these costs. You truly did get the rules attention last October when you introduced the other bill. We believe that S. 1158 is reasonable and responsible legislation for the following reasons:

It recognizes both the value of graduate medical education and its complexity.

Second, it does not disrupt the present academic year.

Third, it supports the primary care specialties and the training of basic physicians or surgeons through public funding, and we consider this provision both fair and wise.

Fourth, it allows for at least a brief period to focus on the more complex issues by mandating the Health and Human Services and Comptroller General studies. Our members stand by to assist in those studies. The recent HCFA regulations are not acceptable to my association.

Fifth, we generally favor the cessation of payment for alien foreign medical graduates; but we do think the bill does this too abruptly, in that there are many such physicians in training and there should be a gradual phasing out or grandfathering of those now in place.

Graduate medical education requires additional stimuli from the Government in order to bring it into more perfect balance. Such stimuli might include, first, provision for reimbursement in out-of-hospital settings such as HMO's, ambulatory care units, and nursing homes.

Primary care residencies as presently funded lose money. In addition, family practice, general internal medicine, general pediatrics, and emergency medicine residencies are not well established politically in most teaching hospitals. They cannot continue to be economically burdensome, or they may be the first residencies discontinued during lean times.

We must continue to develop Medicare and Medicaid funding strategies which favor competitive practices while perfecting access to the poor.

I cannot leave out the malpractice mess. Statutory limits must be placed on malpractice settlements, since they drive so many of these costs.

What must the medical education establishment do on its own? We must totally reevaluate medical school and residency curricula. Second, we must reexamine the makeup of the various certifying examinations as the need to pass these tests tends to drive the curriculum and the behavior of the residents and students. Third, U.S. citizen foreign medical graduates attempting to enter residencies must pass the same examinations as graduates of American schools. The foreign medical graduates' examination in the medical sciences appears to be such a test and goes along way toward evaluating the capability of these students to enter graduate medical education. Fourth, education is, to a large extent, intellectual cloning. Role models are a potent force influencing career choices. Most medical student department chairmen and residency directors are subspecialists. We must expose medical students to practicing physicians, preferably generalists, early and often during their education. Community hospitals provide such exposure routinely.

Fifth, many urban hospitals depend heavily on alien foreign medical graduates for care for the poor. Sudden withdrawal of this work force may cause serious disruptions.

In many cases, State, county, and city authorities contract with medical schools to staff their hospitals. These are frequently models of quality education and patient care. This practice should be expanded, and I am sure the medical schools with Federal, State, and local support will respond to this societal need.

Finally, a brief word about the indirect adjustment. The Commonwealth Fund study demonstrates that the indirect adjustment is a proxy for many things. They include resident to bed ratio, location of the hospital, social severity, bed size, DRG case mix, and area wage index. The study should be broadened to include community teaching hospitals. Reimbursement should be based on these various factors and hospitals specifically, as we are quite heterogeneous.

Thank you for the opportunity to appear before you today. The Association for Hospital Medical Education congratulates you for your leadership on this issue.

Senator DURENBERGER. Thank you very much, Doctor.

Mr. Russell.

STATEMENT

OF THE

ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

SENATE BILL 1158: MEDICAL EDUCATION

PRESENTED TO THE COMMITTEE ON FINANCE

U.S. SENATE

BY

WILLIAM F. MINOGUE, M.D.

PRESIDENT

ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

JUNE 3, 1985

AHME

Mr. Chairman and members of the Committee:

Thank you for the opportunity to testify at this hearing on the financing of graduate medical education.

The Association for Hospital Medical Education (AHME) represents community hospitals involved in the teaching of medical students, residents, interns and practicing physicians. Of the twelve hundred hospitals with graduate medical education programs in the United States, approximately one thousand are non-profit community hospitals. Our member hospitals range in size from two hundred to one thousand two hundred beds. Some of our larger institutions are tertiary care referral centers where the community they serve extends to the state or even nationally. They include such hospitals as Methodist in Indianapolis, the Cleveland Clinics, the Henry Ford Hospital and Hartford Hospital in Connecticut. The smaller hospitals may well serve one community or a rural county and provide only family practice residency training.

Sixty percent of the seventy thousand interns and residents in the United States are trained in our hospitals. Additionally, we train at least three-fourths of all primary care physicians in America. The medical education that takes place in community teaching hospitals focuses first on patient care, with teaching and research as secondary priorities. Education serves the dual purpose of enhancing the quality of medical care and assuring a continuing flow of well-trained young physicians.

The scientific and technological advances in medicine since World War II have served to extend the time necessary to train a competent physician. Following four years of pre-medical education, a student enters medical school and spends his first two years mastering the basic sciences. Years three and four are devoted to the clinical

SCIENCES WHICH ARE TAUGHT AT THE BEDSIDE AND IN THE CLINICS IN TEACHING HOSPITALS. UPON RECEIPT OF THE M.D. DEGREE A YOUNG PHYSICIAN IS NOT PREPARED FOR MEDICAL PRACTICE. IN FACT, VIRTUALLY ALL STATES REQUIRE AT LEAST ONE YEAR OF GRADUATE MEDICAL EDUCATION AND MANY REQUIRE TWO YEARS. ALL SPECIALTIES, INCLUDING PRIMARY CARE, REQUIRE A MINIMUM OF THREE POST-GRADUATE YEARS. THOSE NEEDING THE HIGHEST MASTERY OF TECHNICAL SKILLS MAY EXTEND TO SEVEN YEARS. NINETY-FIVE PERCENT OF ALL GRADUATES OF AMERICAN MEDICAL SCHOOLS COMPLETE A RESIDENCY TRAINING PROGRAM.

RESEARCH IN OUR HOSPITALS IS ALMOST ALWAYS DIRECTED AT SOLVING PATIENT CARE PROBLEMS. AS SUCH, COMMUNITY TEACHING HOSPITALS ARE IDEAL PROVING GROUNDS FOR THE NEW SCIENCE AND TECHNOLOGY DEVELOPED IN ACADEMIC CENTERS. FURTHER, CLINICAL TRIALS OF NEW DEVICES, PROCEDURES OR THERAPIES ARE FREQUENTLY BEST ACCOMPLISHED IN COMMUNITY TEACHING HOSPITALS SINCE THEIR PATIENT POPULATIONS TEND TO BE MORE REFLECTIVE OF DISEASE PATTERNS THROUGHOUT OUR SOCIETY.

GRADUATE MEDICAL EDUCATION ISSUES

I WOULD LIKE TO SHARE WITH YOU SOME OBSERVATIONS ABOUT TWO MAJOR ISSUES, PHYSICIAN MANPOWER AND THE FINANCING OF GRADUATE MEDICAL EDUCATION.

PHYSICIAL MANPOWER

- ARE WE TRAINING TOO MANY OR TOO FEW?
- ARE THEY MALDISTRIBUTED?

FINANCING OF GRADUATE MEDICAL EDUCATION

- SHOULD MEDICARE SUPPORT GRADUATE MEDICAL EDUCATION?
- IS THE CURRENT FUNDING TOO MUCH, TOO LITTLE OR JUST RIGHT?

PHYSICIAN MANPOWER

THERE IS CONSIDERABLE DEBATE OVER WHETHER WE ARE PRODUCING TOO MANY PHYSICIANS. IN RESPONSE TO FEDERAL POLICY, THE OUTPUT OF AMERICAN MEDICAL SCHOOLS HAS DOUBLED IN THE LAST DECADE. IN ADDITION, NUMEROUS YOUNG AMERICANS ARE TRAINING ABROAD AND ENTERING THE U.S. PHYSICIAN MANPOWER POOL. WHILE THERE IS A GENERAL FEELING THAT THERE WILL BE AN "EXCESS" OF PHYSICIANS IN THE 1990'S, THERE IS NOT AGREEMENT THAT THIS WILL BE THE CASE IN THE BEGINNING OF THE TWENTY-FIRST CENTURY WITH OUR SIGNIFICANTLY INCREASING ELDERLY POPULATION AND THE HEALTH CARE THEY WILL REQUIRE.

MANY ECONOMISTS HAVE DESPAIRED OF THERE EVER BEING A COMPETITIVE MARKETPLACE IN MEDICINE. OUR ASSOCIATION MEMBERS ARE ALREADY OBSERVING A HIGH LEVEL OF COMPETITIVENESS. THE COMBINATION OF PRESSURE BY THE GOVERNMENT TO REDUCE COSTS UNDER THE PROSPECTIVE PAYMENT SYSTEM (PPS) AND THE PROFESSIONAL REVIEW ORGANIZATION (PRO) AND THE GROWTH OF ALTERNATIVE CARE SYSTEMS SUCH AS HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND PREFERRED PROVIDER ORGANIZATIONS (PPOS) ARE CREATING A TRUE MEDICAL MARKETPLACE IN THIS NATION. AN ABRUPT LIMIT ON THE NUMBER OF PHYSICIANS WILL BE COUNTER TO THESE FORCES.

THE FEDERAL GOVERNMENT HAS RECENTLY MOVED TO MAKE MEMBERSHIP IN HMOS EASIER FOR MEDICARE RECIPIENTS. THESE ORGANIZATIONS CREATE INCENTIVES FOR PRIMARY PHYSICIANS AND DISINCENTIVES FOR THE USE OF SPECIALISTS AND HOSPITAL-BASED CARE.

WE BELIEVE THAT THE GOVERNMENT FACES AN IMPORTANT ISSUE WITH REGARD TO FOREIGN MEDICAL GRADUATES AND THEIR ENTRY INTO THE U.S. HEALTH CARE SYSTEM. WE HAVE AN OBLIGATION TO PROVIDE TRAINING OPPORTUNITIES FOR THE GRADUATES OF MEDICAL SCHOOLS ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME) AND THE ACCREDITED OSTEOPATHIC SCHOOLS.

WE FAVOR OPPORTUNITIES FOR ALIEN FOREIGN MEDICAL SCHOOL GRADUATES TO TRAIN IN OUR SETTING AS PART OF THEIR EDUCATION PRIOR TO RETURNING TO THEIR RESPECTIVE COUNTRIES. EIGHTEEN PERCENT OF ALL RESIDENCY POSITIONS ARE CURRENTLY FILLED WITH U.S. CITIZEN AND ALIEN FOREIGN MEDICAL GRADUATES.

THE QUALITY OF GRADUATE MEDICAL EDUCATION PROGRAMS HAS BEEN MAINTAINED AT AN EXCEEDINGLY HIGH LEVEL THROUGH THE EFFORTS OF THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION. IN RECENT YEARS SUB-SPECIALTY TRAINING PROGRAMS HAVE COME UNDER THEIR SCRUTINY. IT IS ESTIMATED THAT IN THE VARIOUS SUB-SPECIALTIES OF INTERNAL MEDICINE, TWENTY-FIVE PERCENT OF THE TRAINING FELLOWSHIPS WILL NOT MEET THE STANDARDS AND THUS BE PHASED OUT.

A NEWLY PREPARED FOREIGN MEDICAL GRADUATE EXAMINATION IN THE MEDICAL SCIENCES HAS RAISED THE STANDARDS FOR ENTRY OF THESE STUDENTS TO THAT TRADITIONALLY REQUIRED OF GRADUATES OF LCME ACCREDITED INSTITUTIONS.

IF THERE ARE TO BE CONTROLS ON THE NUMBERS OF PHYSICIANS IN TRAINING, WE BELIEVE THE CONTROL POINT SHOULD BE ENTRY INTO MEDICAL SCHOOL, NOT GRADUATE MEDICAL EDUCATION. ANY ABRUPT REDUCTIONS IN GRADUATE MEDICAL EDUCATION FUNDING WILL BE UNFAIR TO THE STUDENTS CURRENTLY IN OUR SCHOOLS. HOWEVER, SINCE EIGHTEEN PERCENT OF ALL RESIDENTS ARE FOREIGN MEDICAL GRADUATES, THERE MAY WELL BE AN OPPORTUNITY TO REDUCE OVERALL FUNDING.

FINANCING

WE BELIEVE THE FINANCING OF GRADUATE MEDICAL EDUCATION IS A RESPONSIBILITY OF ALL THOSE WHO BENEFIT, OR MAY AT SOME TIME BENEFIT FROM THE QUALITY IT PRODUCES AND FROM THE RESOURCES IT PREPARES FOR THE FUTURE. THE CURRENT

SYSTEM MEETS THIS RESPONSIBILITY, WITH EACH PAYOR CONTRIBUTING A FAIR SHARE THROUGH THEIR HEALTH INSURANCE PREMIUMS. WE FAVOR THE CONTINUATION OF THIS APPROACH. FURTHER, IF ONE WISHES TO CUT BACK ON THE NUMBER OF PHYSICIANS BEING TRAINED IN THIS COUNTRY, A FOCUS ON GRADUATE MEDICAL EDUCATION TO BRING THIS ABOUT IS INAPPROPRIATE. RATHER, CONTROL SHOULD BE EXERCISED AT THE ENTRY POINT IN MEDICAL TRAINING - ENTRANCE TO A MEDICAL SCHOOL.

WHEN DISCUSSING MEDICARE'S CONTRIBUTION TO GRADUATE MEDICAL EDUCATION, IT IS DIVIDED INTO TWO COMPONENTS - DIRECT COSTS AND INDIRECT ALLOWANCES.

DIRECT COSTS - DIRECT MEDICAL EDUCATION PAYMENTS ARE FOR THE SALARIES AND DIRECT SUPPORT OF RESIDENTS AND INTERNS. IT IS THIS TRAINING IN THE CARE DELIVERY SETTING THAT CONVERTS AN INDIVIDUAL FROM A SUCCESSFUL STUDENT TO A PHYSICIAN. AT A COMMUNITY TEACHING HOSPITAL, HE/SHE HAS THE OPPORTUNITY TO PARTICIPATE IN PATIENT CARE IN A VARIETY OF SETTINGS BOTH IN AND OUTSIDE OF THE HOSPITAL. WITH THE EMERGENCE OF ALTERNATIVE DELIVERY SYSTEMS, RESIDENTS SHOULD BE EXPOSED TO THESE COST-EFFECTIVE APPROACHES. IN ADDITION, THE FEDERALLY MANDATED PROSPECTIVE PAYMENT SYSTEM AND UTILIZATION REVIEW PROGRAMS HAVE CAUSED ALL HOSPITALS, INCLUDING THE NATION'S TEACHING HOSPITALS, TO INSIST THAT THEIR PRACTITIONERS CONCERN THEMSELVES WITH BOTH THE HEALTH OF THEIR PATIENTS AND THE FINANCIAL HEALTH OF THEIR HOSPITALS. AS A RESULT, COST CONTAINMENT IS NOW INTERWOVEN INTO THE FABRIC OF GRADUATE MEDICAL EDUCATION AND WILL HAVE A SIGNIFICANT SHORT AND LONG TERM IMPACT.

THE ADMINISTRATION'S PROPOSAL TO FREEZE DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS WILL HAVE INORDINATELY ADVERSE EFFECTS ON COMMUNITY TEACHING HOSPITALS, AS MANY PROGRAMS ARE RELATIVELY SMALL AND WILL DISAPPEAR.

AS RESIDENTS AND INTERNS ARE AN INTEGRAL PART OF THE PATIENT CARE IN COMMUNITY TEACHING HOSPITALS, BOTH QUALITY AND ACCESS TO NEEDED HEALTH CARE WILL SUFFER. WITH INFLATION AT 4.5%, PLACING A CAP ON GRADUATE MEDICAL EDUCATION FUNDING WILL AMOUNT TO A REDUCTION IN THE FIRST YEAR. THE VARIOUS PROPOSALS TO FUND ONLY THE FIRST OR THE FIRST THREE YEARS OF RESIDENCY WILL INEVITABLY DO HARM TO THE SPECIALTY TRAINING PROGRAMS. THIS LONG TERM OUTCOME IS UNACCEPTABLE. WE FAVOR FULL DIRECT FUNDING OF ALL ACCREDITED PRIMARY CARE AND SPECIALTY PROGRAMS WHILE WE WORK TOGETHER WITH THE GOVERNMENT TO DEVELOP A MANPOWER PLAN. MEANWHILE, THE ALREADY EXISTING REGULATORY INITIATIVES OF THE GOVERNMENT AND THE MARKET FORCES NOW IN PLACE WILL PARTIALLY RECTIFY THE PROBLEM.

INDIRECT ALLOWANCES - INDIRECT MEDICAL EDUCATION FUNDING IS BASED ON A FORMULA OF RESIDENTS TO BEDS AND WAS ESSENTIALLY DEVELOPED AS A PROXY TO ACCOUNT FOR THE LEGITIMATELY HIGHER COSTS ASSOCIATED WITH TEACHING HOSPITALS. UNTIL SUCH TIME AS THESE COSTS ARE IDENTIFIED, THE ADMINISTRATION'S RECOMMENDATIONS TO MERELY HALF THEM IS NOT ACCEPTABLE. WE FAVOR CONTINUED DEVELOPMENT OF A SEVERITY INDEX SUCH AS THE ONE UNDER STUDY BY THE PROSPECTIVE PAYMENT ADVISORY COMMITTEE TO THE HEALTH CARE FINANCING AUTHORITY. UNTIL BETTER MEASURES ARE DEVELOPED FOR COMPUTING THIS ADJUSTMENT, WE FAVOR ITS CONTINUANCE AT A REASONABLE RATE.

FINALLY, A NUMBER OF ALTERNATIVES TO THE CURRENT SYSTEM OF FINANCING GRADUATE MEDICAL EDUCATION ARE UNDER REVIEW. THEY RANGE FROM TURNING THE RESPONSIBILITY OVER TO THE STATES, TO THE MEDICAL SCHOOLS, OR TO LIMITING THE NUMBER OF YEARS OF FEDERAL FINANCIAL SUPPORT. WE FIND EACH OF THESE PROPOSALS TO HAVE MAJOR FLAWS WHEN COMPARED TO THE PRESENT SYSTEM. STATES ARE IN NO POSITION TO ESTABLISH TRAINING NEEDS AS EACH IS ONLY A SMALL PART OF AN OVERALL NATIONAL SYSTEM OF HEALTH CARE.

CONCLUSION

OUR CURRENT SYSTEM FOR GRADUATE MEDICAL EDUCATION IS WORKING AND IS NOT IN NEED OF MAJOR REFORM. IT IS BUT A PART OF OUR OVERALL HEALTH CARE SYSTEM, AND OVER TIME IS RESPONSIVE TO THE CONFIGURATION OF THAT SYSTEM. MANY CHANGES ARE NOW OCCURRING IN THE DELIVERY OF HEALTH CARE SERVICES. IT IS ONLY A MATTER OF TIME BEFORE THESE CHANGES ARE REFLECTED IN OUR EDUCATIONAL PROGRAMS.

ABRUPT REGULATORY INTERVENTION WITHOUT A MANPOWER PLAN IS LIKELY TO DO MORE HARM THAN GOOD. ON THE OTHER HAND, WITHDRAWAL OF GOVERNMENT SUPPORT WILL ALSO HAVE SIGNIFICANT ADVERSE CONSEQUENCES. RECENT INFORMATION INDICATES THAT THE MEDICARE PROGRAM IS IN BETTER FISCAL SHAPE THAN HAD BEEN THOUGHT. THIS IS IN PART DUE TO THE REDUCED UTILIZATION OF THE MOST EXPENSIVE COMPONENT OF CARE, NAMELY THE HOSPITAL, AND THE IMPACT OF VARIOUS ALTERNATIVE DELIVERY SYSTEMS. LET US WORK TOGETHER TO DEVELOP A LONG TERM PHSYICIAN MANPOWER PLAN WHILE ALLOWING EXISTING COST REDUCTION PROGRAMS AND CHANGES IN THE HEALTH CARE DELIVERY SYSTEM TO HAVE THEIR EFFECT.

THANK YOU FOR YOUR KIND ATTENTION AND CONCERN.

STATEMENT OF MARK R. RUSSELL, SENIOR VICE PRESIDENT AND CHIEF OPERATING OFFICER, KENNEDY MEMORIAL HOSPITALS, UNIVERSITY MEDICAL CENTER, STRATFORD, NJ, ON BEHALF OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, WASHINGTON, DC, ACCOMPANIED BY MARTIN A. WALL, VICE PRESIDENT, AOHA

Mr. RUSSELL. Hello, Mr. Chairman.

I think I should say that, unlike another Washington, DC, namesake whose name I share, I'm the Mark Russell from New Jersey, and I'm a practicing health administrator.

My hospital, the Kennedy Memorial Hospitals-University Medical Center, is a core teaching affiliate of the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine.

With me is Martin A. Wall, who is vice president of the American Osteopathic Hospital Association. Together, we represent over 200 small to mid-size osteopathic hospitals associated with the American Osteopathic Hospital Association.

Our hospitals are in partnership with our osteopathic physician colleagues who, to a very large degree, practice in the primary care areas of medicine. The osteopathic system is clearly recognized as a full-service alternative delivery system.

I might mention that the osteopathic medical education model is distinctive. The vast majority of our teaching hospitals are relatively small community institutions which serve areas that tend to be in smaller locales. Of our representative membership of over 209 hospitals, 113 of our hospitals are teaching hospitals. Our training programs, to a large degree, produce primary care physicians.

AOHA opposes the 1-year freeze on Medicare payments for direct medical education. In a survey recently conducted of our membership, a great majority of our participating hospitals signified a diminishing interest and lack of support for teaching activities with a more limited reimbursement system.

The osteopathic distinction is evident in our training programs as well. Osteopathic training is approved by the American Osteopathic Association, Bureau of Professional Education. This bill should recognize the osteopathic profession and model and our related training accreditation roles.

The educational, clinical, and regulatory communities long ago recognized the quality of the osteopathic profession. We are a significant medical system, not just limited to a singular practice of medicine. We therefore advocate the removal of the parenthetical reference to our medical practice in the legislation.

We have made our most cogent points in our summary, submitted earlier. We have, in addition, supplied our comments for the record. On behalf of the American Osteopathic Hospital Association, Mr. Chairman, we thank you.

Senator DURENBERGER. We thank all of you for your help in understanding the issue better and, as the other witnesses have done, for moving us in the direction of a realistic commitment to Medicare funding of graduate medical education.

Dick, let me ask you about what is called the exceptions process. Your testimony suggests that we should have an exceptions process for hospitals that are more severely affected than other hospitals. Can you give us sort of a sketchy little outline of what kind of an exceptions process you would suggest, including criteria for categorizing hospitals? And how would we administer it?

Mr. BERMAN. I had some experience in New York with an exceptions process that some didn't think was so good; we thought it was pretty good. And it is difficult, because they are really judgment issues.

On the first category, which dealt with moving beyond the freeze in total dollars for house staff, it seems to me an exception would be based on two things: If you want to encourage more general practice or family practice, or some discrete portion of primary care, then you would say an exception for such an expansion. A second one would be where there has been a consolidation of a program with some documentation of a reduction at another site.

On the foreign medical grad issue, I think I would do it by specialty, and I would probably do it where there is some threshold of percentage of foreign medical grads there now and then give them a longer time to phase down. In other words, I am less concerned with an institution that may have 2 percent foreign medical grads than one that has 25 percent. And again, I would also be more concerned if it was in a primary care area such as pediatrics or psychiatry or internal medicine than perhaps I would be if it is far out in some of the other programs. So those would be at least two elements that I would have included.

Senator DURENBERGER. You have touched on this in part, but Senator Bradley asked me to ask you a question about those few hospitals nationally that have a very high proportion of foreign medical graduates, most of which apparently are located in the center of large urban areas and many of them located in a part of the country that you come from: How will these hospitals be affected by the proposal to eliminate funding for foreign medical graduates? If the proposal is adopted, should a mechanism be established to provide a phaseout of some kind for hospitals with a high proportion of foreign medical graduates, and a mechanism to offset some of the financial losses for the hospitals with high indigent care caseloads?

Mr. BERMAN. I think the way the bill is structured right now, it would be unfair. A disproportionate hit would be on those institutions that serve both a low-income clientele, whether that is urban or rural, and I think we have seen examples in both cases, but the heaviest concentration is where the heaviest numbers are, and that is in the urban centers—New Jersey, New York. As a percentage, they are concentrated primarily in New Jersey, New York, Illinois, Pennsylvania, California, interestingly enough. All of those have over 600 foreign medical grads. And then you go into percentages.

That's why I think you do have to adjust either with an exceptions process or with some formula. And it seems to me that, since there is also a greater number of residency slots than there are U.S.-trained students, if you really want to be helpful in the geographical distribution, then I think that's where I would argue we ought to address it with some positive incentives.

Maybe, to get to one of your other questions, I think it is more appropriate to talk about incentive payments for house staff to go into those areas or those specialties rather than a uniform-number payment for a house staff.

Senator DURENBERGER. Dr. Minogue, your testimony argues that there will be a disproportionate negative impact on community hospitals as a consequence of reductions in both direct and indirect Medicare medical education funding. Why is there a larger impact on community hospitals than on other types of hospitals?

Dr. MINOGUE. I don't believe that the testimony focused particularly on that, Senator.

Senator DURENBERGER. Then I have another question for you. Your testimony argues that it would be better to control future physician supply in medical schools than in residencies. Could you suggest how that could be legislated? Would not some type of a quota system be required?

Dr. MINOGUE. I think some of the slowing down of the growth of the medical schools of course has happened. As you noted, in your State and elsewhere, there is some beginning reduction in size of the medical school classes. My Association does not have a total consensus on this issue. At the very time that we are producing a large number of physicians, we are also seeing physicians taking positions in health maintenance organizations which our profession essentially shunned for a decade and in other alternative delivery systems at much lower payscales than was customary. Our general position is that the marketplace is having a major effect there and may well help the inner-city hospitals by replacing the alien foreign medical graduate, in frequently weak residency programs, by physicians who through incentives would go and practice and work in those areas, and similarly in rural areas, although family practice training has helped that.

In answer to your specific question, I have no good formula. I would not want the Federal Government to begin to dictate the number of students that enter medical school in the first place. It is certainly so, however, that the capitation grants, the modest grants that were available in the seventies, caused this near-doubling of size of our medical schools. So incentive programs in areas where we feel there will be disruptions should be addressed. I don't have those solutions quickly, but we would love to work with you on that.

Senator DURENBERGER. I don't know if any of you want to take on the issue that I raised earlier. There were a couple of parts of the issue; one is that the needs for education expand in the same proportion as the advances in medical technology, broadly interpreted, and that we have to keep adding a semester or a year periodically to the system as well as a certain percentage of economic return at the other end.

Several of the earlier witnesses made quite a point out of the fact that, although they represent specialties, they spend a great amount of their time in primary care. Dr. Ferris, on behalf of the professors of medicine, was making an argument for the subspecialty financing and indicated that six out of the nine subspecialties spend greater than half their time providing primary care, and just giving them more Medicare money to advance their subspecialties seems to be somewhat of an inefficient way to deliver primary care services.

I think we all know that the plastic and reconstructive surgeons don't just do those sorts of procedures that were described here; they do a lot of very basic things like removing moles and a variety of things like that that could be done by people that don't have 7 years of specialty training on top of something else.

The doctor who represented the orthopedic surgeons—and I don't have the figures in front of me—made similar comments about how much time was spent in primary care. And unfortunately for me, he used lower back problems as an example. I don't know how many years it takes to become an orthopedic surgeon, but it doesn't take all of that to diagnose lower back pain accurately, I can tell you from personal experience.

Do you have some general comments on that larger issue of how much education is necessary to do what?

Dr. MINOGUE. I would like to make a personal comment. My association has not had time to digest your legislation and react to that specific issue, but as one who has trained a lot of primary physicians and has spent most of his career in medical education concentrating on that effort, I question whether some of the primary care done by other specialists is in fact comprehensive, continuing primary care or episodic care related to specific organ or body systems. So, it does not meet my definition, personally, of primary care. I think therefore there should be, as I said in my statement, support for primary care specialties, which are politically weak within most teaching hospitals and medical schools. And I think your bill is responsible in that it will probably cause a relook at the curriculum in these subspecialty training programs. If, after that look, the chain of disruption takes place, I am sure we will be back to see you.

Senator DURENBERGER. Well, that was the invitation I made in the beginning.

Any other comments?

Mr. RUSSELL. Yes. I would like to mention that osteopathic residencies range from 2 to 6 years in duration. However, every osteopathic physician, regardless of his future practice goal, must complete a 1-year rotating internship as part of the graduate training. In our view, this is the essence of primary care preparation.

It was also mentioned in earlier testimony that general practice activity in the osteopathic profession is fully 80 to 90 percent of all the care practicing provided by osteopathic physicians in this country. That is a point that I think needs to be underscored.

Mr. BERMAN. Again, one note, and that would be that I think it varies greatly when you talk about medicine versus surgery. Some of the cardiologists I know would meet every definition you would have for primary care. They have their panel, you can call them at any hour, they are your doctor, they happen to also be board-certified in cardiology, et cetera. I think that is a lot different than perhaps the plastic surgeon example. It also varies by the form of practice they are in. If they are in a hospital-based group practice it may operate one way, and if they are in an HMO it may operate another. If you think of the surgical subspecialties as consultant services, then you get one image.

I think that we have a responsibility to you, and you to the rest of the people, to close the open-ended nature of it, so I think we have to find a mechanism. That mechanism may be to freeze the length of time as of today's requirements and take a major act by the Secretary and/or the Congress to go beyond it. I don't think you can leave it open-ended and fulfill the obligations that are upon us.

Senator **Durenberger**. I was pleased to hear all of the physician association and the medical college and teaching hospital group talk in terms of wanting to use the marketplace in general, and let us just make sure we do not try to predetermine the way the marketplace is working.

It occurs to me that there are a couple of areas in which we are not trying to dictate anything but want to make sure the marketplace can work. One obviously is in the way we reimburse hospitals, and particularly now that we start working our way toward some kind of a prospective payment system for physicians. The information that we are learning about the variations in the practice patterns of physicians is certainly interesting. Comparisons being made between your State, Mr. Berman, or in New Jersey, its neighbor, and places like North Carolina in terms of the utilization of specialties and subspecialties are very, very interesting. It looks like the utilization of specialties is in direct proportion to the numbers that happen to exist in the community and need some kind of employment. Now, that probably is not true, but it sure looks like it.

The other area that hasn't been touched on in any depth, and I'm sure it will be over time, is the way in which the change in this country from the individual practitioner to the group practice is going to impact on the educational requirements. Certainly nobody here is dictating that we have corporate medicine and all the things we have been accused of; but the reality is that in many areas the patient is much better off, or the people out there are much better off, if they can get their health care from a mix of primary and specialty service deliverers. And if that is the case, if they are getting them from that kind of a mix, then it isn't necessary that everybody in that group have the maximum amount of education. I mean, everybody has to have some basic training, but after that you don't have to pile on quite as much education.

And yet, I can understand why we have been doing just that—the pressure of malpractice, and a lot of other things. But in that aggregation of professional providers perhaps will come some of the efficiencies or the economies that we seek in medical education as well.

Mr. **Berman**. But just as you have aimed it that way, I think that makes it even clearer why a freeze on the existing distribution, or in fact trying to make each of the schools or each of the hospitals look identical, may be inappropriate.

Senator **Durenberger**. Gentlemen, we are going to have to wind this up. We have some unasked questions that we will send to all of you, but I thank you all very much for your testimony.

At this point, the hearing is adjourned.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

[The following communications were submitted to be made a part of the hearing record.]

association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

June 27, 1985

The Honorable Lloyd Bentsen
The United States Senate
Washington, DC 20510

Dear Senator Bentsen:

Following the appearance of the AAMC's witnesses, Dr. Donald Weston and Mr. Gene Staples, at the June 3 hearing of the Finance Committee's Subcommittee on Health, you asked to have the AAMC respond to two questions:

(1) Do residents in their latter years of training see patients through practice plans associated with teaching institutions?

(2) At what point in their training do residents who work with the practice plan begin to generate income for the plan? Would you provide the Committee with information on the extent of resident participation in practice plans and estimated annual incomes that a typical resident might generate?

Practice plans are the organized groups of faculty physicians in medical schools and teaching hospitals. They vary widely in how they are organized and operate. Because these plans are comprised of some or all of the faculty members who are responsible for the institution's educational programs, residents do see patients throughout their training while under the supervision of faculty members who participate in the practice plan. Residents who are paid for under Part A of Medicare and who see patients as part of their training do not bill fee-for-service (Part B) for the services rendered. However, the attending faculty member who is supervising the resident may bill for any service rendered in conformance with the April, 1969 Intermediary Letter (I. L.) 372, which states:

> "A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician
>
> The physician* must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and

---

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

fulfilled, as the services he renders to his other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must at a minimum:
   a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
   b. personally examine the patient; and
   c. confirm or revise the diagnosis and determine the course of treatment to be followed; and
   d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and
   e. be present and ready to perform any service performed by an an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and
   f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization."

This provision was designed to permit the faculty to allow the residents to acquire the clinical experience needed to become a fully trained physician without having to forego their own professional fees to achieve this goal. However, in some instances, the participation of a resident in delivering the service will prevent another physician from billing. For example, in hospitals sponsoring surgical residency programs, a surgeon may not bill as an assistant at surgery except under special circumstances. (Section 5038, Chapter V, Medicare Carriers Manual)

Thus, as a general rule, residents do not generate income for practice plans per se, nor do they participate in practice plans. There are some exceptions which are notable:

- residents at the Mayo Clinic are supported by the Mayo Foundation rather than Rochester Methodist and St. Mary's hospitals. This is a unique arrangement best explained by individuals at the Mayo Clinic;

- where family practice residents are being trained in "non-provider based settings" (e.g., non-hospital settings which are not eligible to be paid on a cost basis), residents in training are allowed to bill Part B for professional services;

- some residency programs have local requirements that exceed the minimum requirements of the Residency Review Committee for accreditation and the minimum requirements for a resident to become "Board eligible." In some circumstances, residents who have become "Board eligible," but who have not met institutionally set program requirements are awarded instructor status, and allowed to bill under Part B for professional medical services;

- Special certificates (certificates of competence) are granted by a primary specialty board to designate special competence in a subspecialty field represented by that board. Until recently, programs leading to eligibility to sit for the special competence exam were not accredited. For the most part, although the situation is changing many of these programs are still not subject to accreditation standards. Individuals engaged in these programs are usually identified as "fellows". The status of "fellows" with regard to the question of whether they can bill for Part B professional medical services has never been clear. There may be some limited circumstances where fellows are billing for professional medical services under Part B, and these fellows may be members of a faculty medical practice organization.

The Association is unable to estimate the extent to which income for medical faculty practice plans is generated by some residents or fellows, but we are confident the amount of money is not large.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

JAD/jsb

cc: E. Mihalski

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA 1913

55 EAST ERIE STREET CHICAGO ILLINOIS 60611 AREA CODE 312 664 4050

C. ROLLINS HANLON M.D. F.A.C.S.
DIRECTOR

June 21, 1985

United States Senate
Committee on Finance
Washington, D.C. 20510

Attn: Don Muse

Dear Mr. Muse:

This letter is in response to Mr. Mihalski's letter to Oliver Beahrs, M.D., F.A.C.S. dated June 5, 1985. In that letter, it was indicated that the American College of Surgeons' testimony on June 3, 1985 regarding graduate medical education raised several questions by Chairman Packwood and Senator Bentsen.

Chairman Packwood asked: Why is the number of board certified surgeons decreasing while the number of practicing surgeons is increasing? As we state in our testimony, the number of surgeons certified by their respective specialty boards decreased from 4,200 in 1981 to 3,584 in 1983. These figures are published annually by the American Board of Medical Specialties and represent only surgeons who are board certified in a surgical discipline for that year. It should be pointed out that the certification process is voluntary, and even fully eligible individuals may elect not to apply for certification, although this is unusual.

Mr. Don Muse
Page Two
June 21, 1985

The total number of "surgeons" reported by the American Medical Association for 1981 was 113,704. This number increased to 122,232 in 1983. The American Medical Association specialty classification figures are determined by the largest number of hours that a physician devotes to a specialty, regardless of certification. For example, in 1982, of the 118,789 surgeons listed on AMA records, 45,072 were not certified by any American Board. Over 19,000 of those not certified were residents and were not yet eligible for certification.

In summary, certification numbers and numbers of practicing surgeons cannot be compared because they are derived from two different sources of data. While we have no supportive data, it is also possible that the attrition rate for surgeons is decreasing. This is another factor that would be responsible for an increasing number of practicing surgeons.

Senator Bentsen inquired whether "residents in the latter years of training see patients through practice plans in teaching institutions and at what point in training do residents who work with the practice plan begin to generate income for the plan?"

The Medicare regulations are such that physicians in training cannot generate income through Medicare Part B. Instead, residents are compensated through Medicare Part A, the educational pass through, by payment to the hospitals from which their salaries are paid. The level of income generated for a practice plan by residents would be negligible because residents could not be licensed and given hospital privileges as free-standing practitioners during a residency in general surgery.

After a general surgical residency, if the graduates of the residency were given faculty appointments, they might bill directly for the practice plan after performing independently certain procedures in a specialty such as vascular surgery. If more complex vascular surgery procedures were performed with a senior attending surgeon supervising the junior faculty member, there would be billing by the senior surgeon.

I hope this responds to your questions. If we can provide any additional information, please let us know.

Sincerely,

C Rollins Hanlon

C. Rollins Hanlon, M.D., F.A.C.S.

CRH:aa

Response from Clement Sledge, M.D.
to Questions
Posed by Senator Bentsen

Question #1: Do residents in their latter years of training see patients through practice plans associated with teaching institutions?

Response: Residents are usually defined as those participating in an approved training program leading to eligibility for board certification in an area of medicine or surgery; and as such, they are not eligible to bill for services rendered.

Question #2: At what point in their training do residents who work with the practice plan begin to generate income for the plan? Would you provide the Committee information on the extent of resident participation in practice plans and estimated annual income that a typical resident might generate.

Response: As stated above, residents do not bill for services rendered; however upon completion of the training requirements for certification in their chosen disciplines, residents move to "board eligible" status. At this point in time, they become independent practitioners; their salary is no longer paid by the hospital and they can usually bill third party payers for their services. These "board eligible" individuals can and often do see patients through faculty practice plans. However, should the individual pursue training in a subspecialty beyond his/her initial board eligibility training that individual is referred to as a "fellow." During this period of subspecialty training, the "fellow" does not bill for subspecialty services.

In the surgical disciplines, such as orthopaedic surgery, the training program leading to board eligibility consists of at least two major segments:

1. the first segment calls for one year of general surgery; and

2. four years of orthopaedic surgery, with exposure to all elements of the musculoskeletal system for both children and adults.

The salary of the resident during both segments of the training is paid by the hospital.

Thus, residents per se do not generate income to our faculty practice plan.

An individual may chose to spend an additional year at our institution to obtain training in a selected area, such as reconstructive hand surgery. During this additional period, he is referred to as a "fellow" and is usually compensated from revenue generated from the services he/she renders as a "board eligible" general orthopaedic surgeon.

AMERICAN MEDICAL ASSOCIATION

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DIVISION OF LEGISLATIVE ACTIVITIES

HARRY N. PETERSON, J.D.
Director

DEPARTMENT OF FEDERAL LEGISLATION

ROSS N. RUBIN, J.D.
Director

THOMAS M. WOLFF
Legislative Attorney
(645-4769)

June 21, 1985

Edmund J. Mihalski
Deputy Chief of Staff for Health Policy
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Mihalski:

Enclosed are the responses of the American Medical Association to questions posed by Chairman Packwood and Senator Bentsen. These questions are a follow-up on the AMA's testimony at the June 3, 1985, Subcommittee on Health hearing concerning graduate medical education.

Please let me know if you have any questions.

Sincerely,

Thomas M. Wolff

Thomas M. Wolff

TMW:ts
Enclosures
1969p

Question From Chairman Packwood

1. It is my perception that the question of funding graduate medical education has already received intense analysis by such groups as the Graduate Medical Education National Advisory Committee, the AAMC, the Commonwealth Fund Task Force, and others. What will your Ad Hoc Panel add to our knowledge base on graduate medical education? When will your findings be available?

   The AMA's Ad Hoc Panel will provide a unique perspective on the issue of funding graduate medical education because the Panel includes representatives of practicing physicians, academic physicians, residents and medical students. The Panel's report will be available in the near future though the exact date is not known at this time.

Questions From Senator Bentsen

2. Do residents in their latter years of training see patients through practice plans associated with teaching institutions?

   Practice plans are financial arrangements the details of which vary considerably. However, in all practice plans of which we are aware, only faculty are members not residents. Residents frequently see patients of faculty who are members of practice plans. Resident care of such patients is concentrated on inpatient services, but may also include ambulatory care.

3. At what point in their training do residents who work with the practice plan begin to generate income for the plan? Would you provide the Committee information on the extent of resident participation in practice plans and estimated annual income that a typical resident might generate.

   To our knowledge residents do not directly generate income for practice plans because they do not bill for their services. In addition, residents do not participate in the operations of practice plans.

1968p

ASSOCIATION OF ACADEMIC HEALTH CENTERS

JOHN R. HOGNESS, M.D.
PRESIDENT

June 19, 1985

Mr. Edmund J. Mihalski
Deputy Chief of Staff
 for Health Policy
United States Senate
Committee on Finance
Washington, DC 20510

Attention: Mr. Don Muse

Dear Mr. Mihalski

Following are our answers to the questions posed by Chairman Packwood and by Senator Bentsen, forwarded to us with your letter of June 5, 1985.

1. Equalization of Stipends

The Association of Academic Health Centers has proposed that the portion of residents' stipends eligible for Medicare reimbursement should be uniform for all specialties and all hospitals, with adjustments for area cost of living and small increments for seniority.

Chairman Packwood has posed two questions:

a) What are the problems that lead the AAHC to make this suggestion?

b) What are the benefits and costs of such a policy?

The AAHC supports the principle of equalization of pay because:

1) It believes that in time, this provision will contribute to keeping costs in check.

2) It would probably simplify reporting of GME costs.

3) It would discourage offering higher stipends for the purpose of attracting residents. Competition should be based on program quality, not stipend levels.

4) It would neutralize stipend levels as a factor in the selection of specialty by trainees.

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As far as cost benefits, the immediate fiscal impact of such policy on the Medicare program is difficult to assess, but it should not increase costs. We assume that, initially, equalization would be based on a national average of stipends paid in a base year -- say 1985 -- and would be phased so as to minimize financial disruption for presently higher paid residents.

2. Questions from Senator Bentsen

a) "Do residents in their latter years of training see patients through practice plans associated with teaching institutions?"

b) "At what point in their training do residents who work with the practice plan begin to generate income for the plan? Would you provide the Committee information on the extent of resident participation in practice plans and estimated annual income that a typical resident might generate?"

In our view faculty practice plans are primarily mechanisms for billing and distribution of the service fee income of faculty physicians who participate in the plan. To our knowledge, residents do not belong to practice plans or bill for services. However there may be exceptions, especially in the case of very senior residents, and arrangements may vary widely from institution to institution. We do not have any data on this point, and are therefore unable to respond to Senator Bentsen's questions.

We will be pleased to answer, to the best of our ability, any additional questions the Committee may wish to pose to us.

Sincerely,

John R Hogness

John R. Hogness, M.D.
President

JRH/jmd

J. ALAN ALEXANDER, M.D.
Professional Association
1402 MEDICAL TOWERS
HOUSTON, TEXAS 77030
PHONE 790-1604

June 3, 1985

Ms. Betty Scott-Boom
Committee on Finance
Room SD-219
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ms. Scott-Boom,

I would like to request to testify at the hearing on "Medical Education Pass-Through" that has been scheduled for June 3, 1985.

I am extremely interested in finding ways of lowering health care costs without lowering its high quality and without interfering with medical advances.

My opinions to you today are not as a member of the American Medical Association, Texas Medical Association, Harris County Medical Society, American College of Obstetricians and Gynecologists, or of the Houston Surgical Society, of which I am the current President. Instead, my opinions to you today are as a health care consumer that has two elderly parents, a wife, four sons, and a daughter-in-law that are all health care consumers. I say also that these opinions have been formulated by a background that includes:

-Two years as a salaried U.S. Navy physician, Lt. Cdr., stationed at U.S. Marine Station Hospital, Cherry Point, North Carolina, where I was Chief of Obstetrics and Gynecology and Head of the Dependents Clinic.

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-Six years in medical research and teaching at Baylor University College of Medicine, Houston, Texas.

-Eighteen years in private practice in the Texas Medical Center, Houston, Texas, one half of which has been in teaching hospitals and one half in nonteaching hospitals.

My concerns that I would like to address today consist of lowering health care costs by:

1)Prohibiting Medicare payments for graduate medical education.

2)Prohibiting proposals to give states block grants to fund graduate medical education.

3)Prohibiting proposals to federally fund three years of residency training.

4)Prohibiting the leveraging of the system that would create more primary care residencies.

5)Prohibiting the proposal to have the Medicare hospital trust fund contribute to the first year of residency training.

6)Prohibiting the use of any federal funds for residency training except for part B doctors' coverage for those doctors in residency training that treat Medicaid and Medicare patients in city, county, or state indigent hospitals where the resident doctors are ones actually responsible for the patient's care.

7)Prohibiting the development of a severity-of-illness index, which teaching hospitals have sought.

I would now like to address these concerns in detail.

Why should Medicare funds be used for graduate medical education when its intended use is for paying health care costs for the elderly. I say to restrict the use of Medicare funds to its intended purpose. Internship and residency programs are simply extensions of medical school educational programs. The beneficiaries of these educational programs are not the elderly sick, but instead are:

A)The interns and residents themselves, by furthering their educations, increasing their knowledge and increasing their future income potential.

B)The practicing physicians at the teaching hospitals who benefit tremendously from the help and assistance of the interns and residents by:

1)free surgical assistants during surgery.

2)free admission workups with histories and physicals on their patients including the necessary dictations and paper work.

3)free discharge summary dictation.

4)free rounding on their patients.

5)free nightime coverage of their inpatients and outpatients by the interns and residents sleeping in the hospital, frequently being awakened by phone calls, trips to the floors to check on patients, and frequently going to the Emergency Room to see patients sent in by their private physicians who remain at home, permitting the intern and resident to take care of a large percentage of their night time and weekend problems.

6)free coverage of labor and delivery patients, many times actually delivering the patient when the private physician does not make it in time or cannot be located.

I say that the cost of graduate medical education should be borne by those who benefit from it. First of all, I advocate that the private physicians at the teaching hospitals who benefit from all the fine assistance from the interns and residents should pay for it. I practice at a nonteaching hospital and I pay my surgical assistant $18.63/per hour, my scrub nurse $18.63/per hour, and my graduate nurse that dictates my discharge summaries $18.63/per hour. Everytime that the intern and/or resident physician does a service for a private physician in a teaching hospital, he or she should be reimbursed by that physician, whether its seeing a patient in the emergency room or getting up at night to check on a patient that the nurse is concerned about. They should be reimbursed for every delivery of a child that is necessary when the private obstetrician does not make the delivery in time.

Another possible solution would be for the entire medical staff, that benefits from the presence of the interns and residents, to voluntarily or involuntarily establish a residency fund that would adequately pay salaries for the interns and residents.

If it is true that teaching hospitals recieve "sicker patients" than nonteaching hospitals, then let this discrepancy be made up by the payment for the DRG illness rather than increasing reimbursements for all the DRG's just because the hospital is a teaching hospital.

Secondly, if adequate reimbursement of interns and residents cannot be accomplished with the above recommendation, I say to extend the Health Education Assistance Loans program to interns and residents, providing financial aid to them, as it does to medical students. Since this is a government guaranteed but not government funded program, I believe that it would be acceptable by all parties concerned.

For those teaching hospitals that are city, county, or state indigent hospitals where there are no private physicians that would benefit from interns' and residents' help, the funding of salaries could be by Part B Medicare and Medicaid payments for actual services performed. Any additional funding required should come from the city, county, or state governments themselves, not from Medicare funds.

Lastly, I would propose another possible source of funding for graduate medical education. Each teaching hospital could set up a residency training fund from private sources such as:

1) Alumni of the respective residency training programs, who out of gratitude for the training they recieved, would be motivated to contribute.
2) Corporations whose profits benefit from what physicians do, i.e.:
    a) Life insurance companies whose policy holders longevity continues to increase yearly resulting in increased profits. (See Exhibit A)
    b) Pharmaceutical companies whose profits increase because of prescriptions written by physicians. (See Exhibit B)
3) Private foundations.

I would make a plea to immediately stop all present plans to leverage the medical education system. I want to make a plea to open up the system so that any deserving student that wants to become a physician has an opportunity to go to medical school. When he finishes medical school, he should have an opportunity to try to become whatever kind of physician he wants to become, whether eye surgeon, plastic surgeon, or primary care physician.

Presently, 20% of all physicians in the United States are foreign medical graduates. Many of our fine college graduates are having to go out of the country to a foreign medical school because of an inability to gain entrance to one here in this country. Even a larger number give up trying to gain entrance after being turned down and switch to other fields.

I say that this is a shame and disgrace. Every college graduate that wants to go to medical school should have an opportunity to do so. So much competition exists for the restricted number of available spots that too much reliance is placed upon grade point average and MCAT scores. I would like to see it easier to become a doctor, so much so that any college graduate that wants to can give medical school a try.

People say, "well what about the doctor glut?", "we already have too many doctors and too many more coming "down the pipe" (still in training)". I say the more doctors we have, the more competition there will be with lowering of health care costs. I would like to remind people that there are still entire counties in this country without a single physician. There are twice as many lawyers in the state of Texas as there are physicians, and twice as many lawyers in Harris County, Texas, than there are physicians.

	Lawyers	Physicians
Texas	40,000	25,750
Harris County	12,000	6,123

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I say that it should be just as easy for a college graduate to get into medical school as it is for him to get into law school.

In closing, once again I would like to urge you to preserve Medicare funds for their intended use of paying health care costs of the elderly. Federal subsidies for health professions training, which begain in 1965, should be discontinued. The supply of physicians per capita has grown 49% between 1965 and 1983, and surpluses for most health care disciplines are projected for the 1990's. With the surplus of physicians coupled with decreased occupancy rates of hospitals (caused by cost containment policies during the past several years, see Exhibit B), there has developed a fierce competition between doctors for patients, and between hospitals for patients with television and radio commercials, and newspaper advertisements with some teaching hospitals advertising steak and shrimp dinners,(See Exhibit C), as well as free limosine service home at time of discharge, and hors d'oeuvres for guests. Discounts on services are being offered by the different preferred provider organizations (P.P.O.'s) associated with the different hospitals and hospital chains. It is estimated there are 4,000 to 6,000 empty hospital beds each day in Harris County. (See Exhibit D) With this as a background, why should Medicare funds be used to help the teaching hospitals when they are competing so actively against the nonteaching hospitals. I say that it is unfair for Medicare funds to be used to help subsidize the

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teaching hospitals when they are so actively competing with the nonteaching hospitals for patients. You may not be aware of it, but the leading hospital chains, like Hospital Corporation of America and Humana, are seeking to own or manage teaching hospitals. (See Exhibit E)

In a nutshell, the nonteaching hospitals are competing against the teaching hospitals and it is unfair competition since the teaching hospitals are being subsidized by Medicare funds that were intended for health care costs for the elderly. I say let us put a stop to the entire $1.3 Billion indirect aid for health professions education, leaving only the revolving fund for Health Education Assistance Loans.

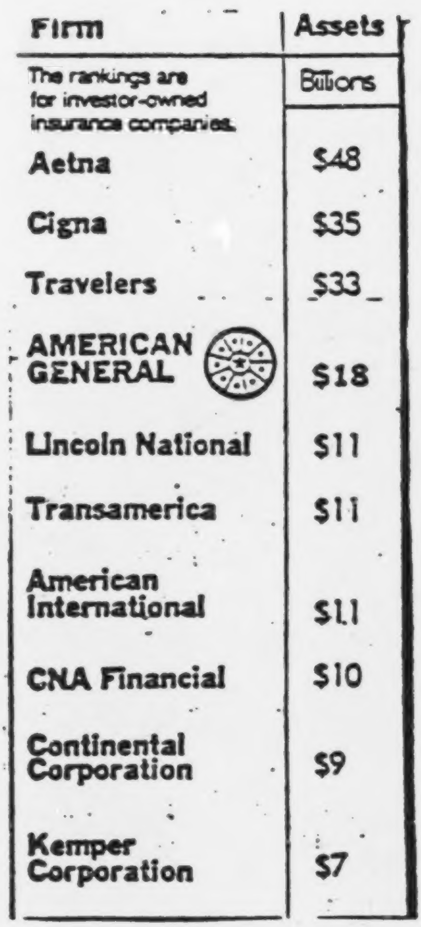
I am very sorry that my request to testify was denied but I do appreciate having the opportunity to have my recommendations included in the printed record of the hearing.

Sincerely yours,

J. Alan Alexander

J. Alan Alexander, M.D.
JAA/npp

EXHIBIT A pg. 2



Firm	Assets
The rankings are for investor-owned insurance companies.	Billions
Aetna	$48
Cigna	$35
Travelers	$33
AMERICAN GENERAL	$18
Lincoln National	$11
Transamerica	$11
American International	$11
CNA Financial	$10
Continental Corporation	$9
Kemper Corporation	$7

Page 2, Section 3 Houston Chronicle Thursday, May 2, 1985

American General has record quarter

By TOM SCOTT
Houston Chronicle

American General Corp., the nation's fourth largest shareholder-owned insurance company, is profiting from its enormous acquisitions over the past few years, even though it has piled up a mountain of debt.

The Houston-based insurance company employs 16,000 people and has 21 million customers. What started in 1926 as a Texas fire and casualty insurer now reports assets of $20 billion and claims to invest an average of $15 million every day.

The company's first quarter results for 1985 are the best in history, said Chairman Harold S. Hook at American General's annual shareholder's meeting Wednesday at Texas Commerce Center's McDade Auditorium.

"This is particularly significant since quarter to quarter results are now comparable for the first time in three years, due to the completion of American General's major acquisition program in 1984," Hook said.

For the first quarter, American General reported net income of $122.82 million, equal to 88 cents per share, compared with $108.3 million, or 77 cents, for the first quarter last year. Revenue for the first quarter was $1.35 billion, compared to $1.35 billion in 1984.

American General's subsidiaries are primarily in the life, health, annuity and property-liability insurance businesses. Other subsidiaries are involved in consumer credit, real estate development and the mortgage banking business.

In 1984, American General acquired Gulf United Corp.'s insurance operations for $12 billion. In 1982, it acquired Credithrift Financial Inc. and NLT Corp.

The NLT acquisition was estimated to have increased operating earnings by $14 million in 1982 and $116 million in 1983. The Gulf United acquisition increased 1984 operating earnings by $79 million.

As a result of those purchases, American General is among the most highly capitalized financial organizations in America. The company's total capital increased more than 200 percent from $1.4 billion at year-end 1981 to more than $4.2 billion at the end of 1984. (The total capitalization of a company is the sum of all securities, including short-term debt, long-term debt, preferred stock, warrants and common stock).

American General's current debt to equity ratio is estimated at 26 percent to 27 percent.

Morgan Stanley & Co. Inc., a New York investment bank, recently put American General on its recommended purchase list, saying the company will achieve per share profits of $3.25 this year (a 61.7 percent advance) and a further 20 percent gain to $3.90 next year.

"Of the 10 largest shareholder-owned insurance organizations in the United States, American General has been able to achieve the second-best five-year compound growth rate in per share total return (21.7 percent)," said Morgan Stanley analyst Norman L. Rosenthal.

In three years, American General has moved from a medium-size insurance underwriter to the fourth largest investor-owned insurance concern, without the impairment of earnings that such rapid growth customarily entails, Rosenthal said.

The firm is the nation's largest writer of home-service life insurance, among the top 10 writers of ordinary life insurance and a major market force in group life and health insurance, property casualty insurance and consumer finance.

Morgan Stanley estimates that consolidation of American General's operations will save $65 million pretax in selling, general and administrative expenses in 1986.

Consolidation of American General will continue

and losses in property casualty insurance have turned around due to an average 25 percent increase in premiums, Hook told shareholders.

Morgan Stanley expects Maryland Casualty to post a major profit turnaround this year and post a $60 million to $65 million profit. The unit lost about $60 million in 1984.

While the federal government does not regulate the insurance business, the company notes in its annual report that "federal initiatives," such as changes in pension regulations or controls on medical costs, can significantly affect the bottom line.

Currently, one issue of particular concern is the possible repeal of the antitrust exemption for the insurance business.

"If this exemption is eliminated, it will substantially affect the way premium rates are set by all property-liability insurers," the annual report states.

Additionally, tax changes by the U.S. Treasury Department will affect the insurance industry. The current tax proposal proposed by Treasury would tax policyholders on a portion of the increase in cash values of permanent life insurance policies. The imposition of such a tax would drastically curtail the sale of permanent life insurance.

The proposal also would discourage the expansion of group life, health and pension benefits by taxing the premiums paid by employers, thus reducing or eliminating plans that are particularly beneficial to people in lower income brackets, the company's annual report said.

Hook said the key financial results for 1984 were that assets increased 27 percent to $19.2 billion and revenues increased 36 percent to $5.4 billion. Total return to shareholders, including stock price appreciation and the dividend yield, was 18.8 percent for 1984. American General is traded on the New York Stock Exchange under the symbol AGC. It closed Wednesday at 31⅛, unchanged.

EXHIBIT A pg. 2

Exhibit A, Page 3

4-16-85

Brainchild of 2 firms

Development company formed

Metropolitan Life Insurance Co. and the Vantage Companies have formed MetVan Property Co., a development organization that will buy or build industrial and commercial properties for long-term investment in Houston and across the United States.

The company is capitalized at $100 million in cash and equity capital put up by Metropolitan and Vantage.

North Belt Business Park is a Houston project developed by Vantage and Metropolitan and offers more than 600,000 square feet of office and warehouse space on a 76-acre site on the North Belt near Intercontinental Airport.

The two firms are also partners in office buildings in Dallas and Denver, industrial parks in Chicago and Minneapolis, a distribution center in Tampa and an office park in Memphis.

John F. Eulich, Vantage chairman, and Henry J. Knapek, Houston division president, note that MetVan has nothing immediate planned for the Houston area and will start operations in Atlanta and elsewhere in the Southeast.

Vantage has developed more than $5 billion worth of commercial and industrial property in Houston and elsewhere since 1969 and operates a Houston divisional headquarters in its own building at 10777 Westheimer.

Metropolitan Life is the second largest company dealing in life insurance and financial services and has total assets of more than $81 billion, including commercial and other properties, joint ventures and mortgage loans in a real estate investment portfolio valued at $20 billion.

8C /The Houston Post/Mon.; April 29, 1985

Ask Us

Is job outlook favorable in health care field?

Joyce Lain Kennedy

CAREERS

(First of three parts)

Q) My daughter was encouraged to use a school computer to identify career choices. Her results point toward work in the health field. The computer says the outlook is very favorable for health jobs. With today's emphasis on cutting medical costs, is this the case?

A) Yes and no. Long-term prospects for a strong job market in health are bright, considering that as the nation's population ages, it will need more health care. But the health job market changes rapidly and even the best computer guidance systems aren't updated frequently enough to reflect current happenings.

And many things are happening in health; some positive, some negative. New cost-containment policies during the past several years have hurt hospital industry, where the majority of health care workers are employed.

In Texas, 40 hospitals have closed in the past two years. Health observers predict that as many as 1,000 of American hospitals may close by 1990.

By no means an isolated example, a recent study of 1,000 health care workers who lost their jobs in Birmingham, Ala., showed 95 percent of the layoffs were in lower-level nursing areas: licensed practical nurses, orderlies and two-year-associate-degree registered nurses.

After two decades, health care growth has slowed down. Industry, labor and insurance companies have organized to control runaway costs by increasing deductible ceilings, which encourages employees to price-shop medical care and to complain about inflated charges.

Moreover, the government's Medicare program for the aged, which pays 40 percent of all hospital bills, has shifted to a prospective payment system. Hospitals are paid a set fee per diagnosis, not what they say treatments cost.

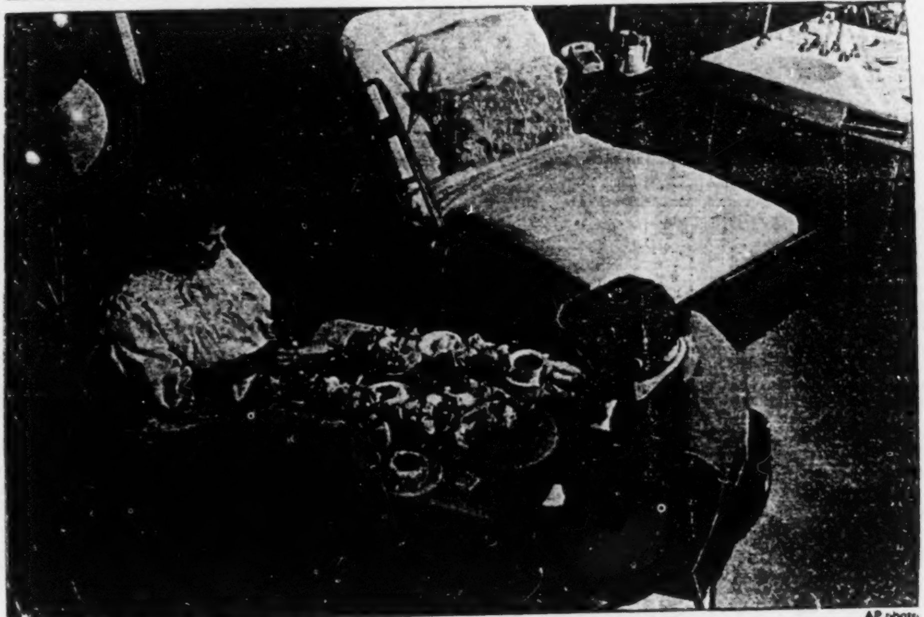
All this means that people are going to hospitals less often and staying fewer days. That's a big reason why the need for lower-echelon nursing care diminished.

Another trend — one that will make working at many hospitals more bureaucratic than ever — is the commercialization of hospitals by private, profit-making companies.

Send career questions for possible use in this column to Joyce Lain Kennedy, P.O. Box 3090, Carlsbad, Calif. 92008. Sorry, the volume of mail makes personal replies impossible.

Exhibit C

/The Houston Post/Sun., May 5, 1985



AP photo

Barbara Blackman and her husband, Steve, enjoy a steak and shrimp dinner hours after their daughter was born.

NASHVILLE, Tenn. (AP) — The couple sits at a linen-covered table toasting each other and eating steak by candlelight. But the setting is a hospital room, where hours before the woman gave birth to a daughter, now snoozing nearby.

6B /The Houston Post/Thurs., May 30, 1985

Private hospitals favor plan of contracting out empty beds

Harris County Hospital District studies Hermann offer

By PETE BREWTON
Post Reporter

Officials with a number of private hospitals in Houston on Wednesday followed the lead of Hermann Hospital, saying they would like to have some of their empty beds used by the Harris County Hospital District.

'Our position is the same as most hospitals — we are certainly willing to do it, if the mechanics can be worked out," Ken Wine, senior vice president of the Memorial Hospital system, said Wednesday.

Every hospital official contacted by The Post Wednesday said they have empty beds available for use by the hospital district.

"We have plenty of beds available, " said Harold Foltik, with American Medical International, a large hospital chain that has 11 hospitals in the Houston area.

Foltik said officials with his company are now reviewing the possibility of contracting empty beds out to the hospital district.

HCA has beds

Dick Kraus, an official with Hospital Corporation of America, another large hospital chain, which also has 11 hospitals in the Houston area, has told The Post that HCA would be willing to work with the hospital district to provide beds.

A spokeswoman for St. Joseph Hospital said, "we are interested in the idea," noting that the 840-bed hospital is no longer using 100-130 of these beds.

St. Elizabeth Hospital, located in the heart of the Fifth Ward, one of the poorest areas of Houston, has made a formal proposal to the hospital district to provide 30 to 50 beds per day. The hospital also has expressed interest in providing outpatient services to the hospital district.

In addition, York Plaza Hospital in northeast Houston and Riverside Hospital in the Third Ward, have made requests to provide the hospital district with beds.

The occupancy rate at area hospitals is down considerably over previous years and is not expected to increase soon. It is estimated there are 4,000 to 6,000 empty hospital beds each day in Harris County.

Most hospital experts attribute this decline to structural changes in the industry that are expected to continue, such as changes in the way Medicare payments are made and increased usage of outpatient services, where the patient is not admitted into a hospital.

Hospital district officials are now studying the 200-bed Hermann offer, with such questions as staffing and cost to be worked out. If the hospital district accepts the Hermann offer and goes ahead with its plan to build two new hospitals, there would be little need by the district for other beds.

The two new hospitals would provide 850 beds — about 100 more than the existing number at the hospital district — at an estimated cost of $700 million over the next 30 years.

It is doubtful the district has the money to build the two planned new hospitals and use the 200 beds in Hermann. Some hospital district officials are now talking about scaling down the two new hospitals, rather than renovating the two existing hospitals and contracting for private beds — which a citizens' coalition opposing the construction of the new hospitals has been urging.

Some hospital and coalition officials are questioning the existence of the hospital district, saying poor people should be able to choose their own doctors and hospitals and should be able to go to the hospitals closest to their homes.

Poor lose dignity

"Why should we send all the poor people to one hospital?" questioned Sister Mary Damian, administrator of St. Elizabeth Hospital.

Such segregation "robs the poor of their dignity," Sister Damian said. She said poor people should be able to go to hospitals in their communities so that they could be close to their families.

A private physician who came up with the Hermann plan along with Don Walker, president of Hermann, echoed Sister Damian's feeling. This doctor, who asked that his name not be used, said "patients have a right and dignity at a time of illness to be treated at a community hospital, except for catastrophic diseases."

Such a system, this doctor said, would allow young medical students and residents to see and treat indigent patients in a community hospital setting.

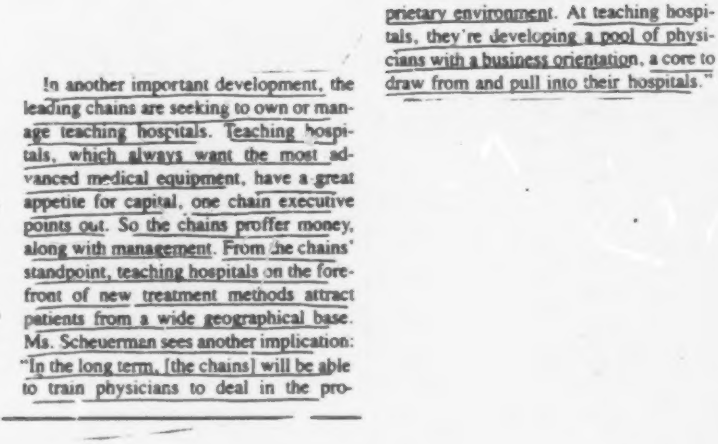
Dick Durbin, administrator of the hospital district, which operates the tax-supported medical facilities for the eligible poor here, said he is uncertain how such a system would work.

He did admit that if the federal-state Medicaid program was adequate enough to take care of all the poor in the Houston area, there would be no need for the hospital district. The patients would pick their own doctors and hospitals which accepted Medicaid.

The hospital district operates Ben Taub Hospital in the Texas Medical Center, Jefferson Davis Hospital, west of downtown, and Quentin Mease Hospital in the Third Ward. It plans to replace Ben Taub with a new hospital and tear down Jefferson Davis.

The district wants to build a 300-bed hospital in northeast Houston near Loop 610 and Lockwood, located in and surrounded by the 100-year flood plain. District officials have acknowledged flooding problems but say the hospital is needed in that poor area.

Exhibit E



In another important development, the leading chains are seeking to own or manage teaching hospitals. Teaching hospitals, which always want the most advanced medical equipment, have a great appetite for capital, one chain executive points out. So the chains proffer money, along with management. From the chains' standpoint, teaching hospitals on the forefront of new treatment methods attract patients from a wide geographical base. Ms. Scheuerman sees another implication: "In the long term, [the chains] will be able to train physicians to deal in the proprietary environment. At teaching hospitals, they're developing a pool of physicians with a business orientation, a core to draw from and pull into their hospitals."

Ke. A

AMERICAN ACADEMY of DERMATOLOGY, Inc.

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May 30, 1985

The Honorable Robert Packwood
Chairman
Senate Finance Committee
SD219 Senate Dirksen Building
Washington, D. C. 20510

Dear Senator Packwood,

Subject: MELANOMA/SKIN CANCER: YOUR HEARINGS ON HEALTH PROMOTION AND DISEASE PREVENTION FOR MEDICARE BENEFICIARIES

This is a request that this letter be inserted as part of the hearing record during your hearings on Health Promotion and Disease Prevention. Specifically, it is to report on the program now being undertaken by the American Academy of Dermatology regarding Melanoma/Skin Cancer, which will impact considerably upon the Medicare population, which because of age, is most susceptible to these diseases.

The Task Force on Preventive Dermatology of the American Academy of Dermatology, aware of the fact that the death rate from malignant melanoma in the USA is increasing at an alarming rate, recommended to our Board of Directors that reversing that trend is feasible and possible through early recognition and prompt surgical excision of early lesions of malignant melanoma. We proposed that the American Academy of Dermatology strive to make death from malignant melanoma a rarity in the not too distant future through public and physician educational programs stressing that there is evidence that recognition and prompt surgical removal of early melanoma results in a high cure rate. The incidence and mortality of malignant melanoma can be reduced at this time primarily by recognition and removal of small, flat evolving lesions of malignant melanoma.

Approximately 100 local societies along with smaller groups of skin specialists organized approximately 400 free melanoma/skin cancer screening programs this spring all over the country. These were held independently or in collaboration with the National Health Fairs. The Skin Cancer Foundation and other service and medical organizations gave support.

One of the most noteworthy examples of the success of this year's screening was in New York City where the dermatologists are well organized and worked together harmoniously in a two-day melanoma/skin cancer screening program; 2,239

AMERICAN ACADEMY of DERMATOLOGY, Inc.
1567 MAPLE AVENUE, EVANSTON, ILLINOIS 60201

persons in Manhattan were given free examinations resulting in the discovery of 200 skin cancers of the basal cell type and 14 melanomas. The melanomas detected were early and the chance for cure very high. This examination was probably life saving for these 14 individuals, none of whom I understand had a family physician or skin specialist.

Also, Mr. Chairman, we would like to indicate that our program was helped considerably by the Senate and House joint congressional resolution signed by the President on March 25, 1985, and its widespread dissemination throughout the Academy membership, on "Skin Cancer Prevention and Detection Week".

We are deeply grateful to you, Chairman Packwood, for co-sponsoring that resolution; to Senator Durenberger, Chairman of your Subcommittee on Health; and to the majority of Members of both the Finance Committee and the Subcommittee who also were co-sponsors.

You will be interested to know that the American Academy of Dermatology has published a special article in cooperation with the American Cancer Society on Early Detection of Malignant Melanoma for Physicians in the May/June 1985 Ca - a cancer journal for clinicians. Also, the American Academy of Dermatology and the American Cancer Society are preparing a booklet on self-examination for melanoma for the public which will be available later this year.

Plans for nationwide physician and public education on the signs of early malignant melanoma are in progress.

We believe these programs will show continuing success, as previous programs in this country and elsewhere already have proved their worth. For example, public and professional educational programs in Queensland, Australia which has the highest incidence of melanoma in the world, in Albuquerque, New Mexico, with a high incidence of melanoma only in caucasians of the area, and in Giessen, West Germany have been successful in reducing the mortality of melanoma. Their public has become aware of the melanoma problem, of individuals at increased risk, of signs of early malignant change in pigmented lesions, of seeking medical consultation promptly, and in preventive measures through educational endeavors. We plan to continue to challenge the American people to do likewise.

We would be pleased to answer any questions that your staff may have regarding this program.

Sincerely yours,

JB Howell

J. B. Howell, M.D.
Chairman
Task Force on Preventive Dermatology
862 Wadley Tower
3600 Gaston Avenue
Dallas, Texas 75246

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE SUBMITTED BY ROBERT CAPONE

Mr. Chairman and members of the subcommittee-

My name is Robert Capone and I am Executive Director of the American Association of Colleges of Podiatric Medicine.

On behalf of our association, I want to thank you for the opportunity to present our views and comments on the subject of graduate medical education and S.1158, as it relates to the field of podiatric medicine.

Medicare support to the field of podiatric medicine perhaps best embodies the original intent of the graduate medical education program. For the severe shortages which first prompted Congress to establish the GME reimbursement mechanism are still very much in existence when it comes to podiatric medicine.

Over the past two decades the number of podiatric medical school graduates has steadily increased, although barely at a rate sufficient to offset the number of podiatrists who have retired from the profession. Consequently, today there are only 9,000 practicing podiatrists in this country -- or one for every 27,000 Americans.

Simply put, Mr. Chairman, this country is now experiencing a severe national shortage of trained podiatrists.

But the problem runs deeper than that. Today and for the next several decades, the elderly will make up the fastest growing segment of our population. As it happens, these are the individuals who are most vulnerable to foot ailments. In fact, Mr. Chairman, about 95 percent of individuals age 65 and over suffer from painful, often debilitating foot problems.

What is more, according to demographic projections over the next half century the over-65 population will double, to 62.5 million. Unless there is an adequate supply of podiatrists, many of these individuals will postpone or forgo treatment altogether, only to face more serious and -- in terms of Medicare reimbursement -- often more costly health problems at a later time. Of course, the problem is even more critical in rural communities, where we find a disproportionate number of the needy elderly -- people who typically require much more medical care than the general population.

Each year, approximately 500 poditaric graduates receive graduate medical training in residency programs at teaching hospitals. Comensurately, each year additional states increase their licensure requirements to include residency training.

So you see, Mr. Chairman, the question of reimbursement for specialties in oversupply is simply not an issue here.

The fact of the matter is that given the current and projected shortages in this field, the burgeoning elderly population, and stricter licensure requirements, any diminution of support for clinical training would only serve to intensify the problem.

For the reasons I have cited, Mr. Chairman, our Association supports that provision in S.1158 calling for a study of nursing and other health professions educational activities. We believe that type of baseline information is essential if we are to obtain an accurate assessment of Medicare's contribution to these very important educational activities.

On the other hand, we believe that an across-the-board freeze on direct cost payments would unduly penalize podiatric medicine. It is our understanding that this provision is included in the bill to permit certain disciplines an opportunity to prepare for the proposed five-year limit on Medicare reimbursements. Since residency programs for podiatric medicine range from one to three years, we believe that such a freeze is inappropriate and unnecessary. In fact, the disruption resulting from a freeze on payments could perhaps worsen the shortage problems I have described..

We thank you for the opportunity to submit this testimony and we stand ready to offer whatever assistance you may need as Congress reviews this important issue.

Rec A

American College of Cardiology
HEART HOUSE 9111 OLD GEORGETOWN ROAD
BETHESDA, MARYLAND 20814 (301) 897-5400

American Heart Association
National Center • 7320 Greenville Avenue
Dallas Texas 75231 • (214) 750-5300

June 10, 1985

The Honorable Robert Packwood
Chairman
Senate Finance Committee
SD 219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

Enclosed is the joint statement of the American College of Cardiology (ACC) and the American Heart Association (AHA) on Medicare funding for graduate medical education. We ask that our statement be made a part of the permanent record of the hearings on this subject held June 3, 1985.

As our statment indicates, ACC and AHA are gravely concerned about the proposal to withdraw support for the training of subspecialists, including cardiologists. Given the important services provided to Medicare beneficiaries by cardiologists, and the expected increases in the aged population in this country, we submit that any drastic changes in Medicare support for subspecialty training is ill-advised.

Thank you for the opportunity to submit this statement for the record.

Sincerely,

William

William W. Parmley, M.D., F.A.C.C.
President
American College of Cardiology

Thomas

Thomas J. Ryan, M.D., F.A.C.C.
President
American Heart Association

Statement of the American College of Cardiology (ACC) and the American Heart Association (AHA) on Medicare Funding for Graduate Medical Education

The American College of Cardiology is a 13,600 member professional society representing physicians who are expert in the provision of cardiovascular medical care. The American Heart Association, comprised of 55 affiliate organizations, over 1,200 local components and more than 2 million volunteers, is the nation's second largest voluntary health organization. ACC and AHA are extremely concerned about issues which impact on the training opportunities afforded to physicians who make the subspecialty of cardiology their vocation. We take this opportunity to comment on S. 1158 and ask that this statement be made a part of the permanent hearing record.

ACC and AHA commend Senators Dole, Durenberger, and Bentsen for raising many of the critical issues deserving of our attention and discussion in the area of Medicare financing of graduate medical education. Moreover, we recognize the leadership role which Senator Daniel Quayle of the Labor & Human Resources Committee has played in the discussions on this subject.

It is our view that S. 1158 contains a number of important and useful ideas for approaches to reforming the Medicare GME system as well as a number of provisions which will have unforeseen and possibly dire consequences for our medical care system.

We support the provisions of S.1158 which would end Medicare support for alien foreign medical graduates. Althougn we fully acknowledge the moral responsibility of the U.S. for fostering the public health throughout the world and we recognize the invaluable contributions made to cardiology by alien physicians working in this country and abroad, we also recognize that in times of budget retrenchment, it sometimes is necessary to eliminate useful and beneficial programs. We agree with the premise that the elimination of support for advanced training of non-citizen graduates of foreign medical schools will produce significant budget savings with a minimal adverse impact on the basic mission of the Medicare program, to provide excellent health care for our nation's elderly. ACC and AHA stand ready to work with the Congress to design a means for assisting foreign physicians in obtaining requisite training in ways which are not so costly to Medicare.

We do not support the provisions of S.1158 which restrict Medicare support to those programs leading to initial board certification. This provision would effectively eliminate Medicare support for subspecialty training, including cardiology training. Cardiologists are required to achieve initial board certification in internal medicine (usually after 3 years of training) before beginning their fellowships in cardiology, which are normally 2 years in length.

Singling out subspecialty training for disenfranchisement is counterproductive to the goal of the Medicare program. Subspecialists, including cardiologists, provide important services to the Medicare population. According to the National Heart, Lung, and Blood Institute, in 1980, about half of all deaths in the 65-74 age group were caused by cardiovascular disease. In the 75-84 age group, the percentage of deaths due to heart disease rose to about 60%, and in the highest age category, 85+, the incidence of deaths due to cardiovascular disease was about 70%. A recent Robert Wood Johnson Foundation study showed that 41% of the patients seen by a sampling of cardiologists were more than 65 years of age and another 25% were between 55 and 64.

The need for the services of cardiology is expected to heighten. Because cardiovascular disease is so age-sensitive, the predicted increases in the number of aged in our society is likely to exacerbate the need for well-trained cardiologists. A March 1985 report by the DHHS Health Resources and Services Administration states that the demand for cardiovascular care is expected to increase significantly between now and the year 2000. With current incentives, it appears that the supply of cardiologists will be adequate to meet the heightened demand, but a major disruption in the system, such as the one envisioned by S.1158 would threaten this expected balance in unpredictable ways. Careful study should precede any major changes in the current system, especially in the case of subspecialty training. With a minimum of fourteen years of post-high school training involved in preparing for a cardiology practice, it is clear that decisions to reduce the number of practitioners are not easily reversed. Change must come slowly and deliberately.

ACC and AHA would also like to use this opportunity to comment on the various proposals for encouraging "primary care" residency training through Medicare. We think this is inappropriate for two reasons. First, the commonly perceived dichotomy between primary care and specialty (or subspecialty) care is not a clear one. The R.W. Johnson study mentioned earlier showed that for almost 60% of his patients, the cardiologist provides the majority of medical care. Put another way, patients with heart conditions often consider their cardiologists their primary care providers. This data suggests a blurring of the perceived distinction between primary and specialty care which must be examined very carefully before major changes are made in the system.

Our second concern about Medicare incentives for the establishment of traditional primary care residency positions centers on the apparent illogic in the idea of Medicare, a program designed to aid the elderly, being used to encourage additional numbers of pediatricians and ob-gyns. Even if we accept the need for additional "primary care" providers, in the traditional sense, we remain doubtful that Medicare should be the vehicle to implement such policy.

For these reasons, we respectfully ask that the disenfranchisement of cardiology and other medical subspecialities be eliminated as an option in discussion about reform of the graduate medical education system supported by Medicare. Cardiologists, as we have stated, provide vitally important services to the Medicare population, and look forward to doing so on an expanded basis in the years to come. Elimination of the important Medicare subsidy for training subspecialists would severely disrupt the current balance and would return us to a time we thought was well behind us when only the wealthy could aspire to careers in the interesting and challenging medical subspecialties.

Thank you for the opportunity to express our views on this important subject.

A

AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
and
CONGRESS OF NEUROLOGICAL SURGEONS

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CHARLES PLANTE
Washington Liaison
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(202) 659-1373

June 3, 1985

The Honorable Lloyd Bentsen
United States Senator
United States Senate
Washington, D.C. 20510

Dear Senator Bentsen:

We are writing in support of Senate Bill 1158 that you, Senator Dole, and Senator Durenberger have introduced. We congratulate you on trying to deal with the issue of how to appropriately fund graduate medical education. You have given this critical aspect of medicine, exposure which it certainly needs. While we understand the principal thrust of your bill is cost containment, we are aware that it also addresses some other rather difficult issues.

Particularly, we are in support of a study of teaching versus non-teaching hospitals; this, plus the study of cost of the education of certain support medical personnel, such as nurses, is most appropriate. We would hope that the study of the teaching hospitals would touch on the issue of the impact of limiting graduate medical education to five years. We feel that these studies will give a better understanding of the true costs of graduate medical education, and from that information, perhaps one can derive more appropriate mechanisms to fund it.

During the period of the study, we support the concept of freezing the funds available for graduate medical education at their current levels. This should give ample time for the studies to be done. Reallocation of funds can then be done with a much better understanding of the needs and the requirements of the system.

We are supportive of your withdrawal of Federal dollars for the education of foreign medical graduates, whether U.S. born or foreign born. We concur in your view that it is an inappropriate use of taxpayer funds. While we support the concept that American medicine, as the world leader, should extend its knowledge and skills to the rest of the world by educating physicians in our country, we recognize this as separate from the issue of Medicare funding. Perhaps a specially designated fund for this purpose could be created if it would serve the national interest. In our view, it would.

We would like to speak to that section of the bill which places a five-year limit or to the level of initial board certification, as the time frame for graduate medical education supported by Medicare. As Neurological Surgery is one of the specialties which requires six years of training, we would request that the phrase "to initial board certification" be the cap on the time frame.

In that context, we would like to point out that, currently, only Colon and Rectal Surgery, Dermatopathology, Neurological Surgery, Plastic Surgery, and Cardiothoracic Surgery exceed the proposed five-year requirement. According to data from the Accreditation Council for Graduate Medical Education, these specialties occupy 1,594 positions out of the 72,397 total residency slots filled in 1983. Therefore, the amount of money saved by a restriction to five years would not be substantial.

Limitation either to five years, or to Board Certification raises some problems. It would be helpful to those of us in the field of graduate medical education if the sense of the Congress on these issues were known.

One of the issues which arises is the definition of "initial Board certification." Both Cardiothoracic and Plastic Surgery require Board certification in General Surgery before beginning training in those specialties. Would, under this bill, such General Surgery certification be considered as primary, and thereby, eliminating Federal funding for residents in Plastic and Cardiothoracic Surgery? There were 708 slots filled in these specialties in 1983. Again, not a significant amount of money would be saved by such an interpretation.

As we interpret the bill, funding would not be allowed for the rare, but important physician who wishes to be cross-trained in two specialties. For instance, an individual might wish to be Board certified in Pediatrics and Surgery. Would this be funded? Again, it is not a lot of money, as this is an unusual situation. But such individuals offer the likelihood for breakthroughs in both knowledge and patient care.

We also feel that some provision for increasing the length of training should be incorporated. As knowledge increases, logically, the time required for acquisition increases also. Perhaps such increased training time might be approved by the Secretary of Health and Human Services, if it can be shown, and documented, that such increase is required by enhanced knowledge within the specialty. It should also be reflected in improved patient care.

We would respectfully request that this letter be made an official part of the hearings on S1158.

Senator Bentsen
June 3, 1985
Page Three

We appreciate the opportunity to make these remarks. We will be glad to answer any questions which you or your staff may wish to raise.

With our best regards,

Robert Ratcheson, M.D.
President
Congress of Neurological Surgeons

Russell Patterson

Russel Patterson, M.D.
President
American Association of
Neurological Surgeons

Rec. June 5 A

American
Psychiatric
Association

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Irvin M. Cohen, M.D.
Recorder

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American Journal of Psychiatry

John A. Talbott, M.D., *Editor*
Hospital & Community Psychiatry

Robert J. Campbell III, M.D., *Editor*
Psychiatric News

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John Blamphin
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Jay B. Cutler, J.D.
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Carolyn B. Robinowitz, M.D.
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Steven S. Sharfstein, M.D.
Deputy Medical Director

Jeanne Spurlock, M.D.
Deputy Medical Director

Jack W. White, D.B.A.
Deputy Director, Business Administration

June 17, 1985

Hon. Robert Packwood
Chairman
United States Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Chairman:

The American Psychiatric Association, a medical specialty society representing over 31,000 psychiatrists nationwide, is pleased to provide our comments on S.1158, legislation introduced by Senators Dole (R-KS), Durenberger (R-MN) and Bentsen (D-TX) to alter the method by which Medicare provides payment for the direct costs of approved educational activities. We request that these comments be made part of your Committee's Subcommittee on Health's hearing record of June 3, 1985.

At the outset, the APA wishes to express its appreciation and support for the sponsors' efforts to address some of the critical and difficult issues with regard to Medicare's changing role in financing graduate medical education. We are particulary appreciative of their acknowledgement that the existing system of financing graduate medical education is complex, and that changes must be carefully evaluated and considered so that they do not threaten the nation's ability to train qualified physicians in sufficient numbers to meet the physical and mental health needs of our nation in the future.

While we congratulate the authors for recognizing many of the complexities of the current graduate medical education system, and for dealing with them in a generally fair and rational manner, we have several specific concerns that we would like to bring to your attention.

S.1158 requires a limit on the number of years that will be financed under Medicare; the lesser of five years, or the formal training needed to satisfy the requirements for initial board eligibility in the specialty in which the resident is being trained. We believe that the concept of this provision provides a responsible approach to limiting the current system of open-ended reimbursement and other proposals to limit Medicare's GME reimbursement. We are particularly pleased that it responds to the needs of general psychiatric residents, who must train for four years in order to be board certified. We are most concerned, however, about the effects it will have on child psychiatry -- a medical specialty in documented shortage -- which requires an additional year of residency after initial board certification. As you may know, numerous studies over the past few years, including those by the Heritage Foundation, the Rand Corporation, and the DHHS Report of The Graduate Medical Education National Advisory Committee and Health Manpower Development (GMENAC) have specifically identified both general psychiatry and child psychiatry to be in a present and projected future condition of national shortage. In fact, GMENAC, while projecting an overall surplus of approximately 70,000 physicians nationwide by 1990, projected a shortage of between 3900 and 5900 child psychiatrists. It also projected that there would be a shortage of 8500 general psychiatrists by 1990. The only other specialties projected for a national shortage were emergency medicine and preventive medicine, both of which have 3 or 4 year residencies and would be fully reimbursed under this provision. Child psychiatry, however, the medical specialty with the most acute shortage, would be denied Medicare reimbursement for the last year of residency training. We feel it is crucial that our nation encourage medical students to go into the field of child psychiatry in order to fill these tremendous needs.

Therefore, we urge you to amend S. 1158 and provide an exception under section (P)(ii) for any medical specialty that has been designated by a Federally chartered committee on graduate medical education to have a current and/or projected shortage. We would welcome the opportunity to work with you on specific language for such an amendment.

The Medicare program currently makes no distinction between funding residency positions filled by graduates from medical schools accredited by the Liaison Committee on Medical Education, and funding graduates of foreign medical schools that are not accredited. S.1158 provides that beginning July 1986, Medicare would no longer reimburse for the direct medical education costs of a resident who is not either a graduate of an accredited medical school in the United States or Canada, or a citizen of the United States or Canada.

We would recommend consideration be given to those FMG residents already in training to allow for completion of their residency, and also that a "substantial disruption waiver" be included to allow an orderly transition for those hospitals (mostly inner-city and rural teaching hospitals) that rely disproportionately on alien foreign medical graduates to meet current patient needs, particularly the chronic and homeless mentally ill.

Finally, we agree and support the American Medical Association's position that all Federal programs (including defense) should accept a fair share of the burden in reducing the deficit. We would be willing to support the freeze proposed in S. 1158 on Medicare payments for direct medical education for one year if it were part of an across-the-board freeze on all domestic and defense spending. We must in principle, however, oppose further cuts in health programs that require such programs to bear a disproportionate burden of deficit reduction.

The APA is pleased to have had this opportunity to present its views on S. 1158, and we look forward to working with the Committee during its deliberations on the issue.

Sincerely,

Carol Nadelson, MD

Carol Nadelson, M.D.
President

CN:pr:mg

cc: Members of Senate Finance Committee

Ave A

American
Psychological
Association

TESTIMONY

of

John E. Carr, Ph.D.

Professor of Psychology and Acting Chair
Department of Psychiatry and Behavioral Sciences
University of Washington School of Medicine

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION OF MEDICAL SCHOOL PROFESSORS OF PSYCHOLOGY

presented to

THE UNITED STATES SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

on the subject of

MEDICARE DIRECT PAYMENTS FOR MEDICAL EDUCATION

Hearing held June 3, 1985

The Honorable David Durenberger, Chair

1200 Seventeenth St., N.W.
Washington, D.C. 20036
(202) 955-7600

Mister Chairman and Members of the Subcommmittee, I am Dr. John E. Carr, Professor of Psychology and Acting Chair of the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. I am also President of the Association of Medical School Professors of Psychology, whose members represent the majority of the nation's medical schools. The following statement, on the S. 1158 proposal for Medicare direct payments for medical education, is offered on behalf of the 76,000 members of the American Psychological Association, and the Association of Medical School Professors of Psychology. We were grateful to be invited to speak on this issue at hearings before this Subcommittee in October, 1984, and are pleased to continue our involvement.

The process of medical education and health professions education concerns psychology for several reasons. Psychologists both receive education as health service providers, and participate as faculty in the education of the entire range of health professionals from physicians to allied health providers. In fact, approximately 1000 psychologists serve as clinical/teaching faculty in nearly all of the nations 128 major medical schools. Along with physicians, psychologists are typically the only doctoral level professional to attain such status in medical schools. Psychologists are similar to physicians in their education process; internships must be completed as part of their doctoral training. Generally, two years of supervised experience are required for licensure for the independent practice of psychology. Thus, the provision and availability of internship positions are of vital importance to psychology. The support of these positions by the Medicare direct payment for medical education is a concern because 48 medical schools include affiliated hospital-based, accredited psychology internships and are therefore eligible for this support.

Psychology is an important example of the non-physician health professional who has not yet been taken into account in assessing the broader impact of adjustments in Medicare's education payments. Currently, data are available on the numbers of physicians involved in training and, partly for this reason, there is some confidence in making changes in sources of support for physicians. Previous predictions of physician shortage have now been replaced with evidence of surplus in many medical specialties. Because of this, limitation on payments for medical education are accepted as necessary and logical — but the implications of this for other health professionals needs to be fully explored.

It would be unfortunate if in making changes to save federal dollars based on the estimated adequacy of one type of health professional, other health professionals would suffer. Thus, we were very pleased to note the stipulation in S. 1158 to study the Medicare support of "approved educational activities related to nursing and other health professions." S. 1158 is the first legislative proposal addressing the Medicare medical education payments that specifically includes attention to the impact on non-physician education programs.

Psychology would definitely be affected by the freeze on direct payments proposed in S. 1158. Currently, psychology qualifies in numerous affiliated teaching hospitals as an "approved education program." A facility that serves as a training site for psychology interns can, on appropriate application, include incurred costs as those of an "approved program." Psychology intern stipends paid by the hospital may then be reimbursed by the direct medical education payments. This mechanism is used to support the internships of psychology doctoral students. We are now conducting a survey to determine more clearly the extent of this support and will gladly share this information with the Subcommittee.

Direct Medicare payments also pay salaries of teaching physicians who are on hospital staff. Psychologist faculty, even though they perform many of the same duties and functions as physician faculty, do not receive their salary in this way. Our concern here is for the dual clinical/teaching character of both physician and psychologist teaching faculty. We would like to see a clarification in the statute stipulating that these payments may be made for the salaries of all clinical/teaching faculty, whether they be physicians or psychologists. This definition would accurately reflect the teaching and clinical services functions that occur, and would assist hospital administrators to more accurately reflect the services that take place in the hospital.

The teaching role of psychologists is also profoundly affected by the scope of coverage allowed for nonphysician services in Medicare. In addition to payments specifically earmarked for medical education, Medicare supports the education process by reimbursing for the clinical services of medical school faculty in teaching hospitals. These payments provide a source of revenue for medical schools. We are not referring to an additional cost or adjustment added on to patient service charges, but a legitimate charge for the rendering of professional services. Recent policy discussions indicate that as federal support for medical school-based research and training programs becomes limited, clinical revenues will play an increasingly important role in assuring a medical school's fiscal solvency. Because of the importance of clinical revenues to the medical school budget, medical school faculty are often required to generate clinical revenues as part of their employment contract. Clinical faculty members can generate revenue by billing either independently for services to teaching hospital patients or through a mechanism such as a faculty practice plan.

The bundling provision of the prospective payment system makes it mandatory that all nonphysicians be compensated by the hospitals in which their services are performed; this is the unique way that the Medicare program affects psychology's role in medical education. Many teaching hospitals are reluctant to pay for psychologist's services when they do not have to pay for the same services if provided by a physician who can bill directly for them. This promotes inefficiences, and can mean that psychologists are unable to meet the terms of an employment contract. What can happen is one of three things:

1) The psychologist delivers the services but reimbursement is not made by the hospital. This is happening in several locations that we

can identify. Eventually, the services will either be performed in a manner to cause unnecessry costs, by someone inappropriately trained, or not performed at all.

2) The services are being performed, and direct reimbursement is made to the faculty practice plan with the psychologists' services buried under physician services. This is a theoretical possibility that would result in added costs from unnecessarily increasing physicians involvement, lost efficiencies, and complicated or duplicated administrative work.

3) The services are not being offered at all.

This restriction on billing prohibits an accurate reflection of the service system by the reimbursement mechanism. It is often wasteful, causes unnecessary repetition in service reimbursement, and can be deliterious in terms of patient care. More straightforward reporting of reimbursable services would enable the reimbursement system to accurately reflect the health care service delivery system.

The Association of Medical School Professors of Psychology estimates that there are about 3,500 psychologists on the faculties of most of the nation's 128 major medical schools. This includes teaching, research and clinical faculty. We estimate that up to 1,000 of these hold the position of full-time clinical/teaching faculty and are doctoral level, licensed psychologists. They function as full-time faculty, and serve in an "attending" role on units within affiliated teaching hospitals. They provide a full range of administrative, teaching, and clinical services. They supervise psychiatry and psychology residents, other medical specialty students, graduate students, and house officers. Medical school departments have come to rely on psychologists to expand curriculum and to incorporate attention to cognition, learning, attitude, and behavioral aspects of health in training the range of health professionals. In addition, psychologhist's services expand and supplement organically-based, often more expensive, biomedically oriented, technology-intensive physician services. Both psychologist and physician faculty are required to generate clinical revenues as part of their faculty contract. But, departments cannot bill Medicare for the services of psychologist faculty in teaching hospitals as they can for the services of physician faculty. We are asking the committee to let doctoral level, clinical/teaching psychologist faculty carry out their responsibilities and be paid for them in the same manner as physician clinical/teaching faculty.

A solution to this situation would be to allow all clinical/teaching faculty in medical schools to bill directly for their services. This would include doctoral licensed psychologists who deliver services in teaching hospitals as part of their faculty contract.

To summarize, we have two concerns: one is the impact any changes in the amounts or mechanism of the Medicare medical education payments would have on the education and training of non-physician health professionals. We support the attention paid to this issue in S.1158 by asking for a study of Medicare support for other health profession education. We will be glad to make our own data on the number of psychology interns in medical school hospitals available to the committee to assist in this process.

In addition, we are concerned about psychologists in clinical/teaching positions as full-time medical school faculty because of the restrictions in reimbursement under Medicare for the services of nonphysicians. We would like to see psychologist faculty able to be reimbursed for their services in the same way as their physician colleagues. This would avoid unnecessary, and likely repetitious, administrative or clinical requirements and associated costs. We have suggested a direct way to accomplish this, through statutory change, and urge the Committee to consider our proposal.

Thank you for the opportunity to present our concerns.

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STATEMENT

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

MEDICARE PAYMENT FOR
GRADUATE MEDICAL EDUCATION

SUBMITTED FOR THE RECORD TO:

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE

JUNE 3, 1985

The Blue Cross and Blue Shield Association, the national coordinating agency for the nation's Blue Cross and Blue Shield Plans, appreciates this opportunity to present our views on S. 1158. This bill would reform Medicare payment for the direct costs of graduate medical education, that is, the salaries of resident physicians and related costs in teaching hospitals. We also would like to address the related issue of payment for the higher costs per case associated with care provided in teaching hospitals that are in addition to direct education costs. In sum, we believe that:

- S. 1158 is a good interim approach to Medicare payment for direct graduate medical education expenses, though the 5 year limit on the length of residency training that Medicare would help finance should be phased-in more gradually.

- In the long term, a method should be developed to identify more precisely and pay only patient care-related costs of direct medical education.

- Severity indicators and other adjustments should be developed as the basis for paying the additional "indirect" costs incurred by teaching hospitals, but the current payment approach for these costs should be retained until such adjustments are implemented.

Payment For Direct Medical Education

S. 1158, introduced by Senators Dole, Durenberger, and Bentsen, would freeze Medicare payments for direct medical education costs for one year, effective for hospital accounting periods starting on or after July 1, 1985. For accounting periods beginning on or after July 1, 1986, the bill would limit the number of years of residency that

Medicare would help finance. The limit would be the lesser of 5 years or the number of years required for initial board eligibility. S. 1158 also would prohibit Medicare payments for training non-citizen foreign medical graduates and mandate studies comparing costs of teaching versus non-teaching hospitals.

The Blue Cross and Blue Shield Association shares this Subcommittee's concern about the cost of the Medicare program and the need to continue to assure high quality care for Medicare beneficiaries. In our opinion, this bill meets those objectives better than the Administration's proposal, which consists only of a freeze on direct medical education payments. By itself, a freeze on the direct costs of graduate medical education represents only a short-term response and does not address any of the underlying issues. In addition, we are pleased that the sponsors of S. 1158 recognize that teaching programs in our nation's hospitals have had direct and positive effects on the quality of patient care and that Medicare's financial support of these programs has helped to assure the provision of quality care to its beneficiaries.

Conceptually, direct medical education costs can be divided into two categories — those that are related to the actual provision of needed care to patients and are therefore the responsibility of payers of health care, and those that are not. We believe direct medical education costs that are not related to patient care should ultimately be borne by some financing mechanism other than that intended to support patient care. Other sources of support include hospital philanthropy, hospital operating margins, and federal and state support programs. This principle has always been recognized by Medicare. The Congressional Committee reports accompanying the original Medicare legislation stated with regard to medical education costs, "(I)t is intended until the community undertakes to bear such costs in some other way, that a part of the net costs of such activities should be considered as an element in the cost of patient care..." The practical difficulty in evolving from the current system in which major payors help finance the full costs of medical education activities is that there are no available data or methods to separate these costs into patient care and physician education components. Moreover, recognition must be given to the availability of alternative sources of support. Until such time as these major issues can be addressed, it is appropriate to consider interim approaches to enable Medicare to define more precisely the types and extent of direct medical education activities it will help finance.

The approach taken by S. 1158 would involve Medicare more directly in medical manpower policy considerations. One apparent objective of the bill is to provide incentives for resident physicians to choose primary care training rather than training in subspecialty fields, many of which already are in oversupply. It also would help reduce the oversupply of physicians by prohibiting Medicare payment for training of non-citizen foreign medical graduates. In addition to the Part A medical education savings, the bill has the potential for savings under Part B and under private health plans by limiting specialists. Specialists generally receive greater unit payments than primary care physicians for the same procedures, although there is some evidence that certain specialists receive less total payments for the treatment of particular illnesses.

We are not certain that S. 1158 will have these effects, however, because the response of teaching hospitals and physicians-in-training to the new Medicare reimbursement criteria is hard to predict. The bill may simply provide incentives to restructure the way subspecialists are trained. For example, cardiologists typically take a three year internal medicine residency followed by a two year cardiology fellowship. In response to the bill, this pattern could evolve to a four year integrated cardiology residency without providing for Board eligibility in internal medicine during the course of training.

Another factor to be considered is that the bill might actually increase Medicare Part B payments. Because Part A reimbursement would no longer be available for the salary and related costs of Board eligible physicians, there will be an incentive for these physicians to become licensed and begin billing Part B on a fee-for-service basis for patient care they provide to beneficiaries.

On balance, however, we believe S. 1158 is a good interim approach. A precise accounting for direct patient care-related costs does not appear feasible soon, so an interim approach seems appropriate until such a refinement can be developed. The Department of Health and Human Services has undertaken a major study of graduate medical education costs and we hope its findings will provide the basis for the consideration of long term reforms. While the specific effects of the bill are uncertain, we believe it is important to establish incentives for change in institutional teaching programs to assure that the nation's needs for physician manpower are met in the most efficient and effective manner. We are concerned, however, that limiting the bill's phase-in to one year may be disruptive to many hospitals having to making major changes in their teaching programs. In addition, this brief phase-in may be disruptive to residents currently in a subspeciality training program. We recommend that you adopt a longer phase-in or make the new criteria effective for residents who entered subspeciality training after a specified date.

Also, the Subcommittee may want to consider modifications to S. 1158 that would preserve the incentives for positive change in institutional teaching programs without involving Medicare so directly in medical manpower decisionmaking. For example, it might be possible to determine the amount of Medicare payments for direct medical education costs using the 5 year training limitation while providing hospitals with the flexibility to allocate those funds as they determined appropriate.

Payment for Indirect Medical Education: Future Options

While S. 1158 does not address Medicare payment for indirect medical education costs, we understand that the Subcommittee intends to pursue this issue in the future.

The indirect teaching cost adjustment is based on the fact that the cost of hospital care, on the average, tends to be higher in teaching hospitals than in non-teaching hospitals. Presumably, these costs are related not only to the practice patterns of interns and residents, but also to the characteristics of the patient population. A major argument for the teaching adjustment has been the higher costs associated with the sicker patients that teaching hospitals treat. The accuracy of the adjustment factor, based upon the relationship between operating costs per discharge and residents per bed, has always been debated. We share the Administration's skepticism regarding the accuracy of the adjustment. Doubling the adjustment may, in fact, have only magnified its inaccuracy. However, we would be equally concerned with arbitrarily reducing the total by half, as recommended by the Administration.

An adjustment for severity of illness seems the most appropriate single approach to recognize necessary indirect medical education expenses. However, no practical severity indicator is presently available. We, therefore, strongly encourage intensive study of severity of illness indicators and other means of rendering the payment system more sensitive to an individual institution's actual clinical load, retaining the incentives of prospective payment. There are few solid data on how the severity of case loads in teaching institutions compares with that of non-teaching institutions. In the absence of better severity indices some Blue Cross Plans have recognized severity through broader use of outliers. Medicare may wish to consider a similar approach.

Many teaching hospitals also serve a "disproportionate share" of low income patients, thereby incurring added expenses for security, social services, and inner-city labor costs. Until consensus is reached on severity of illness and "disproportionate share" adjustments, it is appropriate to retain the current method of recognizing the indirect costs of medical education activities. The General Accounting Office study mandated in S. 1158 regarding costs of teaching versus non-teaching hospitals, and the ongoing HHS study of graduate medical education costs, should provide information on future reform options.

We understand that the indirect adjustment is used by many teaching hospitals to offset indigent care costs. We believe indigent care costs should be addressed explicitly. We do not see them as an appropriate function of the indirect adjustment. As a practical matter, however, it should be recognized that withdrawing the indirect adjustment without simultaneously addressing the financing of care to the poor could have an adverse effect upon those hospitals which have a high percentage of patients unable to pay. The financing of health care for the poor is a major public policy issue facing our nation. We believe that government at all levels and the private sector must work together to find feasible solutions to this problem, and we would be pleased to assist this Subcommittee as it explores this important area.

Conclusion

In conclusion, we commend the Subcommittee, particularly Chairman Durenberger, for pursuing this important issue. We believe that S. 1158 is a good interim approach to Medicare payment for direct graduate medical education expenses, though we recommend a longer phase-in or a change that makes the new criteria effective for residents who entered subspeciality training after a specified date. In the long term, methods should be developed to identify accurately and pay only patient care-related medical education costs.

We would be glad to offer any assistance to the Subcommittee in this effort. Thank you.

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STATEMENT OF

HOWARD UNIVERSITY HOSPITAL

Medicare Financing of Graduate Medical Education

Presented to the
Subcommittee on Health
Finance Committee
U.S. Senate

Haynes Rice
Hospital Director
Howard University Hospital

June 10, 1985

Modification of the Medicare Direct Medical Education Program is the most serious issue in the health care industry today. I, therefore, appreciate having the opportunity to share my views on this subject with the Senate Finance Committee.

Howard University Hospital is the largest minority-run teaching hospital in the country. We are located in the nation's capital and service a large indigent, poorly educated population.

There are several other hospitals like ours, Meharry of Tennessee, Morehouse of Atlanta, and Martin Luther King/Charles Drew Medical School in California are among them. We all share the unique responsibility of not only caring for individuals who are often unable to adequately provide for themselves, but educating them as well on the necessity of good health care. The task is awesome but we do it with the knowledge that a nation is only as healthy as its citizens.

We have watched with interest the progression of efforts to change the Medicare program. We wholeheartedly endorse the government's commitment to bring spending under control before it is too late. We cannot, however, in good conscience, support all of the proposed suggestions for changing the Direct Medical Education Program.

In the May 16th Congressional Record several questions were stated demonstrating your concern that changes not be made without careful thought. I believe it is imperative that I take the time to answer those concerns from our perspective.

First of all, you were interested in learning how much a hospital saves by having residents providing services normally provided by physicians and other hospital staff.

We, at Howard, estimate that the savings is approximately 200 percent. You see, residents earn about $20,000 a year and work about 80 hours a week. We would have to pay a physician $60,000 for only 40 hours of service.

This leads me to conclude that the answer to your next question about whether the interns were thus paying for their graduate medical education with the response, yes -- a thousand times over!

It should be understood that our hospital could not survive without their patient care skills or their assistance in training medical students. Their presence stimulates the care process to a level not present in non-teaching hospitals. It, therefore, stands to reason that the absence of these health care providers would be very costly to the hospital and to the third party payers as well who are looking to reduce costs.

Ultimately we would be forced to reduce our teaching programs and our caseload, turning away many of those self pay patients who flock to our hospital because they are denied care at most hospitals in the area. This would create a larger problem because we would have to spend more on these patients at a later date due to the delaying of their treatment.

In addition, we would have to require physicians on duty to do many of the tasks now assigned to the residents and payment under part B of the Medicare Program would rise significantly. Studies on the payment aspect of hospital administration should be carried out without delay.

I should also like to discuss another area of concern to me and my counterparts in other urban and rural hospitals -- Foreign medical graduates.

Howard University made a commitment to countries in Africa and the Carribean many decades ago to provide training and assistance to improve the quality of life for their citizens. We believed that it was a good foreign policy investment to train the young men and women who would someday lead their countries. That assumption has proven to be a good one in that students from years past, like the late Dr. E. Latunde Odeku, Professor of Neurosurgery and Dean, Faculty of Medicine, University of Ibadan, Ibadan, Nigeria and Dr. Festus Halay, Former Dean, College of Medicine, University of Liberia, Monrovia, Liberia, have held positions of authority.

We are afforded a respect in foreign countries that is unsurpassed by few institutions of higher learning. If we change our policy on this important matter, it would send a negative message to those countries, many of which are in the Carribean and are being beckened to change their philosophies every day.

To further make this point, it should be noted that the Office of Assistant Secretary for Management and Budget/U.S. Department of Health, Education and Welfare conducted a 1979 "Special Analysis of Foreign Student Enrollments at Howard University." The analysis was made to determine if foreign students should be assessed higher rates for their tuition.

Several conclusions were reached by the investigators:

.This contemplated change could affect relations between the U.S. and other nations, particularly the developing nations of Africa and Latin America from which Howard attracts the bulk of its foreign students.

.Given the special relationship between Howard and the Federal Government, such as a shift could be interpreted as a signal of overall Federal policy with regard to foreign students. If other publicly supported institutions followed the Federal policy lead, the impact of this apparently minor change at Howard could have national repercussions.

.U.S. Citizens studying abroad could be adversely affected. To date, U.S. students have not been treated differently with respect to tuition charges at foreign institutions. However, a conscious decision by the Federal Government to change Howard's policies could stimulate similar moves by foreign governments.

Can you imagine the repercussions from a policy change on the admission of FMGs to our program?

Wouldn't it be more economical in the long run to strengthen our immigration laws to ensure that Foreign medical graduates are returned to their homelands? After all, they would still be allowed to receive training in other foreign medical schools and would eventually enter the U.S. as physicians after having passed the FLEX.

I want to also state that the ECMFG examination process has recently been restructured. In fact, 200 students are scheduled to take a clinical skills exam later this month which is not required for U.S. students. This screening factor plus the pass/rate scale for those students taking the ECMFG exam will automatically eliminate those persons who are unworthy.

I need to address a final concern on the issue of the Foreign medical graduate. Who would replace them in the urban hospitals which currently rely on their presence for needy patient services.

It is imperative that lawmakers realize that urban and rural hospitals in many of the states have large numbers of FMGs in their programs. Most U.S. medical students look elsewhere for their training because the environment and the facilities often are not comparable to those in the more prosperous areas. This leaves a gap in providers for the services needed and medicine has sought to use FMGs to meet this need.

I believe that it would be shortsighted and devastating to the health community and the patients involved to remove the FMGs without proper planning. I would, therefore, like to suggest that consideration be given to assigning health service corps participants to those areas and providing direct assistance to those public hospitals involved, simultaneously, if your proposal to eliminate the FMG is approved.

In addition, since it has been proven that minorities are more likely to practice in the less appealing areas, you might also want to consider modifying health professions programs to generate more minority participation. The loan forgiveness concept for health profession program participants who practice in less attractive areas should also be considered as an option to ensure that all Americans will have access to good health care.

I should like to close by requesting that your committee carefully review the points made in this statement because they mirror the concerns of all of the minority teaching hospitals in this country. We, at Howard, understand that changes are necessary, we just hope that they will be made only after a detailed study of the program has been completed.

TESTIMONY TO FINANCE COMMITTEE
RE: MEDICAL EDUCATION COSTS
PASS-THROUGH UNDER MEDICARE

There seems to be no doubt that the number of physicians now being trained in the U.S. is sufficient to meet the health needs of the nation - more than sufficient. But within that number there is still a disadvantageous distribution of the kinds of physicians being trained - disadvantageous from the point of view of the true needs of the public. Any change in U.S. policy about paying for graduate medical education should take this into account. To cut federal payment for graduate medical education "across the board" will do disproportionate damage to primary care training programs that the nation clearly needs to promote better, low cost health care for all of its people.

Postgraduate medical education in the United States of America (and perhaps undergraduate medical education as well) has trained legions of specialists but too few generalists. It was not until about 20 years after the second World War that physicians and others began to realize that the "free market" in medical training was not producing a balanced medical manpower supply, but was leading to a serious dual maldistribution of physicians: there were too many in the city and too few in rural areas; and in both places there were too few generalists and too many specialists.

At a time when it seemed that physicians were in short supply foreign medical graduates came into the country in increasing numbers - and have continued to do so - and in their choice of postgraduate training they made worse the maldistribution of medical specialties, crowding into the specialized, high technology fields and largely leaving family practice, general internal medicine and pediatrics untouched.

Family Practice, as a specialty, grew out of General Practice in 1969 and a large part of the impetus for the development of this specialty was the realization that urban and rural people need competent general physicians to care for their every day needs and to refer them when necessary to specialists. The costs of postgraduate medical education have risen steadily and now are judged excessive (along with the costs of many other domestic programs). But if the payment for postgraduate medical education is too high, if the total number of physicians being trained is too many, is not now the time to establish a system of national priorities?

Now is the time to use the method of reimbursement for medical education to induce the training of physicians that the country most needs - family practitioners and other primary care physicians.

At the present time there are 72,000 interns and resident physicians in the United States of American. About 14,000 of these are foreign medical graduates, some truly foreign born, others United States citizens who trained abroad. As Petersdorf argued (reference 1) it seems certain that we could entirely dispense with the services of those 14,000 foreign medical graduates. The schooling of physicians in foreign countries is, for the most part, markedly inferior to U.S. medical education, and if we now have a surplus of physicians training and entering practice, the first place to reduce numbers in the interest of quality is in foreign medical graduates. This is as true for U.S. citizens who are trained in foreign schools as it is for foreign born persons trained in their own countries.

If that were done, the remaining 58,000 housestaff positions (internship and resident positions) could be filled by the current U.S. medical school graduates. Each year 18,000 physicians receive their M.D. or D.O. degree and enter a postgraduate training program, usually a three year residency. Thus, there are 54,000 U.S. graduates to fill housestaff positions when trained over three years. Petersdorf (ref. 1) agrees with this total of 54,000 housestaff positions. Further, he shares the view of many experts that 10% of these positions or about 38,000, should be "primary care" trainees, i.e., in family practice, general internal medicine, pediatrics or obstetrics and gynecology.

If this were done, the numbers of trainees in these specialties would be the same or a little more (in the case of internal medicine, family practice and pediatrics) or only slightly fewer (in the case of obstetrics/gynecology) than is true now. And the general support for postgraduate medical education, it seems to us, would properly be directed so that there would be inducements to physicians entering these specialties for their training.

No one really disagrees with the general idea that primary care physicians including family physicians should be our highest priority in paying for postgraduate training. The truth of the idea is self-evident. One cannot find surgeons who will say that surgery should be given the highest priority. To cut all training programs "across the board" including family practice and the other primary care specialties, is an illogical idea considering the priorities. The GMENAC report of 1980 projects that numbers of general and family practice physicians will be in slight surplus in 1990, ignoring the undoubted fact that family practitioners should be trained to replace other physicians whose training is unsuitable for the areas of need in rural medical practice.

Family practice training emphasizes cognitive skills and teaches physicians to take care of patients close to home without undue dependency on high cost technology. The fee structure of family practice tends to moderate the cost of medical care. Family practitioners as trained in the United States in the 1980's are suitable for the care of patients in rural underserved areas and it can be shown that the quality of care provided by such physicians is excellent. They provide comprehensive medical care that suits the needs ~~of the vast~~ majority of patients. The maldistribution of physicians in the United States has not been remedied by the National Health Service Corps approach: but it is clear that family physicians trained locally tend to stay in greater numbers in underserved areas than do physicians trained in other primary care specialties such as internal medicine.

Family practice training in the last decade has clearly provided us with a number of physicians whose skills and knowledge enabled them to work in small communities and redress the maldistribution that was so prevalent in U.S. health care. Furthermore, family practice as a specialty began by insisting on periodic re-examination of physicians who are certified as specialists in family practice - the only specialty to make this requirement. This is an important advance in insuring the quality of care.

Family Medicine training programs emphasize caring for patients in their family setting from the time of birth to the time of death: health maintenance organizations testify to the importance of family practice in their staffing ratios: 70 to 90 percent of the physicians are in primary care and of those two-thirds should be family practitioners. A description of the kind of care afforded by family practitioners can be obtained from John McPhee's Heirs of General Practice published by the New Yorker Magazine in 1984. McPhee explores the great variety of care that family practitioners can give patients - care that is personal and concerned but care that also has access to technology where it is needed.

Family practice training which is done in medical school affiliated hospitals gives a role model to medical students encouraging them that this can be a kind of career that will be satisfying in every way. Thus, if postgraduate family practice training can be encouraged it will help to foster the interest of medical students in family practice. It is very important to have an opportunity to attract the most intelligent students into this specialty because the challenges are great - greater than in almost any other field of medicine - and we must have the best students to meet that challenge.

We urge that the Committee not alter the pass-through under Medicare in such a way that family practice - and other primary care specialties - are made to suffer from relative lack of support. This would be the result of an "across the board" cut. The patients will be the sufferers if this happens. We urge that the Committee consider the welfare of the patients and the public as a whole which can best be served by supporting primary care training at least to the same degree as is true now.

/ss
6/7/85

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STATEMENT OF THE STUDENT NATIONAL
MEDICAL ASSOCIATION

TO THE

Subcommitte on Health of the Senate
Finance Committee

Re: Direct Financing of Graduate Medical Education

June 10, 1985

Presented by: Gisele Thornhill,
National Chairperson, Committee on Legislative Affairs
Student National Medical Association, Inc.

The Student National Medical Association (SNMA) was established in 1964 due to a recognition of the need to produce an increasing number of particularly sensitive and excellent physicians to serve minority and indigent communities. These communities suffer disease, illness, and deprivation which in comparison to the majority community is both appalling and unacceptable. Thus, the SNMA was founded to foster within the student an obligation to excellence, and to produce high quality health care team members armed with the knowledge, skill, and insight to practice medicine within the minority community.

As an independent, national non-profit organization the SNMA has and continues to direct the thrust of its energies toward issues addressing health education and health care delivery, in addition to a perennial crusade toward responsible representation of minorities in the health professions. In congruence with these goals and purposes, the SNMA welcomes this opportunity to provide testimony to the Senate Finance Subcommittee on Health regarding the direct financing of graduate medical education.

In the Senate Congressional Record of May 16, 1985, Mr. Durenberger asserted that Medicare support for graduate medical education was deemed appropriate in the past because:

> First, the physicians, nurses, and health professionals in these programs provide service to Medicare patients.
> Second, virtually all other payers had traditionally been willing to pay their share of these education costs.
> Third, it was felt that these educational activities enhanced the quality of care in hospitals, and
> Fourth, in the 1960's and early 1970's, the view was widely held that there existed a shortage of quality trained physicians, nurses and other health professionals.
> But times have changed since 1965. The Nation now faces a growing surplus of physicians.

It is the contention of the SNMA that opposition to the present policy of financing graduate medical education is not so much due to a physician surplus, but rather due to the fact that third party payers are no longer willing to pay for the rising costs of medical education given the current trend of escalating health care costs and federal and private budgetary pressures to reduce expenditures.

Under S.1158, a bill to amend Title XVIII of the Social Security Act with respect to Medicare payments for direct costs of approved educational activities Mr. Dole, Mr. Durenberger, and Mr. Bentsen make a number of presumptions in presenting suggested reforms for direct financing of graduate medical education:

1)The recommended reform in Medicare financing of graduate medical education will not dictate specific requirements for the distribution of training programs to hospitals and affiliated medical schools.

2)The Medicare program can impose fiscal restraint in the manner prescribed without causing "undue or potentially harmful disruption to graduate medical education".

3)The State and local governments are capable of assuming an increased responsibility in direct financing of clinical training in teaching hospitals.

4)The medical schools and teaching hospitals are capable in the current competitive and economic environment to take on more financial responsibility in training residents and remain competitive.

5)The cost incurred in a teaching hospital does not directly benefit third parrty payer sick subscribers and therefore third party payers should not have to assume the responsibility of financing graduate medical education.

6)There are only three ways to decrease total Medicare costs to the U.S. Treasury: cut back benefits, increase beneficiary cost sharing, or decrease payments to providers.

These presumptions will be addressed in the following discussion.

Discussion

The implications of the suggested reforms for financing medical education with respect to health manpower outcomes is of great concern to the SNMA. Although, the current proponents of reform believe they are not dictating specifications for the distribution of training programs, but rather imposing financial constraint to encourage hospitals and medical schools to be sensitive to the economics of their training decisions, the interest in directing manpower distribution has been clearly stated by Mr. Durenberger in the Congressional Record,

> "The combination of these financial signals and market forces should lead to more constraint in institutional training policies, particularly as regards the number of subspecialty slots made available.
>
> The contraction of subspecialty slots likely to result should shift emphasis more to primary care training. In this way, more physicians will choose to end their graduate medical training at the still first-contact specialties...It is good Medicare policy and good physician manpower policy to produce more first-contact physicians."

The SNMA does not contend the need for more primary care or first-contact physicians, particularly given the fact that many of the minority and indigent communities have the greatest shortages of primary care physicians and physicians in general. The SNMA believes, however, that the process by which the Medicare program would contribute to a shifting of emphasis to more primary care training is not without deleterious ramifications nor is there a guarantee that the suggested proposals will bring about the desired manpower outcomes.

If the Medicare program freezes its financing of direct costs of medical education with a limit on the number of years of financing set at five years it is very likely that the number of non-primary care specialty slots will contract, but whether graduate medical students possibly opting to end their graduate medical training at the first-contact specialties will be able to secure a position as a resident in these specialties must be questioned given the possible negative effects of financial cuts and freezes on teaching hospitals.

The above alludes to the premise that changes in financing graduate medical education can be made without causing harmful disruption of the current system.

If the Medicare program does indeed freeze payments for direct financing of graduate medical education, it is likely that other third party payers will follow suit. The national Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the Washington Business Group on Health have already begun questioning their support of graduate medical education. Similarly, a number of national health insurance associations are retreating from their support of teaching hospitals by entering agreements with lower cost non-teaching hospitals to treat patients enrolled in health maintenance organizations and preferred provider organizations. In addition, other financing sources for residency training namely, federal support, in the form of primary care training grants authorized under Title VII of the Public Health Service Act are eliminated under the President's FY 1986 budget proposals. The budget proposals also suggest a reduction in funding of biomedical research, further reducing hospital revenues. Given the economic times, with cuts and freezes the teaching hospitals will certainly have to decrease the number of subspecialty and non-primary care slots they offer. The question the SNMA poses is will teaching hospitals be able in this economic environment to sustain current primary care slots, yet alone expand them?

One might suggest the States will be able to help in this regard. Mr. Durenberger expressed this in the same Congressional Record cited above.

> "The medical school deans, hospital administrators and physicians I talk to give me the sense that teaching hospitals, even the foremost in the Nation, are beginning to feel the stress of price competition...
>
> The health services industry is the third largest employer - after retail and wholesale trades - in Chicago, New York, and Boston. In these cities alone a total of over 500,000 people are employed in health care. The dominant health care institutions in these cities are the large teaching hospitals.
>
> These same institutions provide the lion's share of health services to the poor in the cities. These teaching hospitals enhance the cities' quality of life and stature by providing a broad range of tertiary care services and by engaging in biomedical research. When considered in these terms, State and local governments need to realize it is in their best interest and the interest of their communities to see the academic

medical centers sustained."

The SNMA suggests in addition to financial pressure imposed by the Medicare program, freezes in financing the States may also have to limit their contributions to graduate medical education. Indeed, the States are concerned about their own financial welfare given the federal cuts of the past and those that are proposed for FY 1986. Therefore, State and local government resources for approriations toward graduate medical education are tenuous at best.

Under the above conditions and given the consensus that teaching hospitals incur a greater cost for operation, even under the best of circumstances, teaching hospitals are at great risk if the current forms of financing are changed without careful planning that takes into account the complexity and interdependence of the health care system and graduate medical education. If teaching hospitals are put at risk not only is graduate medical education affected but undergraduate education as well. In addition, the population of patients traditionally provided services by teaching hospitals are also affected.

Assuming that the minimum negative out come is a decrease in the number of subspecialty slots without an increase in primary care slots the result will be increased competition among graduate medical students for primary care slots as well as for the fewer subspecialty slots. This is of particular concern to the SNMA given the results of the 1984 National Resident Matching Program. This data showed that black males have the highest unmatched rate at 21.2 percent, followed bv Hispanic males with 18.6 percent, black women with 18.2 percent and Hispanic women at 15.2 percent. Majority men and women unmatched were 7.7 percent and 6.3 percent respectively. These percentages are likely to increase in a greater competitive atmospher, and will affect minority graduates to a much greater extent than their white couterparts.

The decrease in the number of residency slots will serve not only to increase competition among senior medical students it will affect the quality of medical education at the undergraduate level. Third year medical students depend on residents for educational instruction for their clerkships. Third year clerkships provide crucial instruction, providing the first hands-on clinical experience for medical students. This is the time when medical education becomes the most important and most relevant with respect to patient care. The availability of an ample supply of residents to accomodate the needs of medical students with respect to supervision and instruction is already at a premium, particularly in the municipal hospitals affiliated with medical schools. To insure the production of competent first year residents and a return on the investment in a medical education made by the student, his or her family, and the federal government by virtue of educational loans there must be an ample supply of resident to provide training and supervision during clerkships.

One may argue that if medical schools want to insure that a stable supply of residents are available for their students they must take on a greater responsibility for financing them. In FY 1978-79. the Council of Teaching Hospitals identified sources of revenue for resident and clinical fellow education and training. Medical school support was only 2.7 percent for residents and 4.6 percent for fellows. Since the beginning of the 1980's one can assume these percentages have increased, but not to such a significant amount as to render the medical schools a source to greatly expand residencies. Given the current lack of student scholarships and low interest loans for medical students and the climate of astonomical tuition costs, it is safe to say a large portion of medical school funds are used to provide financial assistanct to medical students. Therefore, as a financial resource for teaching hospitals the medical school is at the bottom of the list.

Proponents of change in financing graduate medical education point to an oversupply of physicians, particularly in the non-primary care specialties, as another point in their favor to encourage support of their proposals. During the early 1960's the Federal government was concerned about an impending shortage of physicians. Enactment of Medicaid and Medicare increased this concern since these programs created access for the poor and elderly, amplifying the demand for physician services. The years between 1963 and 1971 saw legislation which concentrated on increasing the number of physicians. Incentives were created which resulted in expansion from 87 medical schools graduating 7,300 physicians annually in 1963 to 126 schools graduating 16,000 physicians annually in 1982. During 1970 to 1972, government concern turned towards the geographic maldistribution of physicians.

As stated previously, the SNMA does not contend the need to decrease the number of physicians entering non-primary care specialties. One must take care, however, not to oversimplify the problem of physician surplus as the President did last October saying, "Although there may be some shortages of physicians and nurses in particular areas of the country the nation as a whole is facing a future surplus-not shortage- of physicians and nurses." The well known discrepancies in physician to population ratios between whites and minority populations is unacceptable. Assertions of a physician surplus belies the fact that there is a preminent and dangerous shortage of physicians in many areas of the country.

The well touted report of the Graduate Medical Education National Committee (GMENAC) stated that there will be a surplus of physicians by 1990. However, the report also emphasized the continuing need to increase the number of minorities in medicine and the continued geographic maldistribution of physicians.

Data has shown the absolute numbers of minority medical students has increased with expansion of the United States capacity to provide medical training. However, it is also true that the new slots for medical students created by past health manpower legislation have been overwhelmingly distributed to white and affluent students. Information provided by the National Resident Matching Program (NRMP) states that,

> The practice setting most preferred by 1984 graduates was a city of moderate size (population 50,000 to 500,000) chosen by 29 percent of the respondents. Small towns and rural areas were the least preferred settings, each selected by about one percent of respondents. Seventeen percent indicated that they plan to locate in socio-economically deprived areas. (emphasis added)

Dr. Robert Montoya,(M.D., Ph.D.) of the office of Statewide Health Planning and Development in California, has noted that approximately 80 percent of minority health professionals voluntarily practice in or adjacent to designated health manpower shortage areas, providing services largely to underserved minority patients. In 1950, 2.1 percent of all practicing U.S. physicians were black, by 1980 this figure increased by only .5 percent to a figure of 2.6 percent.

In addition, studies done by the RAND Corporation conclusively show that physicians are beginning to diffuse into previously underserved areas due to market forces generated by a greatly expanded supply of physicians. Physicians are overflowing from saturated urban areas into towns and areas with populations of 25,000 and up. However, this effect has not reached the communities with populations of less than 10,000.

Other supply controversy consists of fear of the growing population of foreign medical graduates (FMG's) seeking residency training in the United States. In 1984, over 10,000 FMG's participated in the match system for residenty slot assignment of which 7,143 were aliens (AFMG's) and 2,922 were U.S. foreign graduates (USFMG's). In the opinion of the SNMA, based on NRMP data the contribution of foreign medical graduates to the "oversupply" of physicians relative to U.S. graduates is not as threatening as the initial numbers portend.

Of the total number of FMG's, 4,244 became inactive prior to the matching process for residency assignment. If those that became inactive are added to the 4,309 who went unmatched , it is apparent that 8,553 of the FMG's who applied in the match of 1984 did not obtain a position. Moreover, the NRMP states that it is clear that other categories of applicants do not compete with U.S. seniors when the position-to-applicant ratio drops. The percentage of U.S. senior students unmatched has remained below 8 percent regardless of the relationship of positions offered to active applicants with respect to the categories of applicants. Of the FMG's who did match 80.2 percent did so in the primary care specialties and general surgery. If one counts psychiatry the figure approaches 88 percent, both figures being well above that for U.S. graduates.

The problem of oversupply therefore resolves to one of maldistribution and inadequate supply of minority physicians leading to an inability to supply shortage areas. Therefore, given the above discussion, the SNMA must assert although the primary care physician supply needs to be expanded tying manpower initiatives to Medicare policy, howbeit indirectly, is not the best way to achieve this objective given the inability of teaching hospitals to expand their slots in the face of an uncertain financial future, one which is compromised by:

1)the inability to predict future financial resources to keep up with inflation and to compete for staff and residents with non-teaching hospitals who incur less costs.

2)a lack of finances to secure more faculty and space, even if the possibility of expanding the number of primary care slots existed, necessary to accomodate a greater number of residents and to increase patient loads to provide opportunities for clinical education.

3)shifting of insured and paying patients to less costly and more competitive hospitals by HMO subscribers, contributing to less resources to cross-subsidize patient care for those who cannot pay for health care.

Besides these points, NRMP data shows that under the current financing status almost 500 new primary care slots were offered to applicants in the 1984 match system.

The argument that teaching hospitals do not directly benefit third party payer sick subscribers can be contested by the statement made by J.D. Meyers in the 1981 Journal of Medical Education for the month of September:

> "It is argued that patients should not pay educational costs. This view neglects two facts: patients benefit from services they receive when residents participate in their care in teaching hospitals, and 94 percent of all hospital revenues are now derived from third party payers. These insurers - whether voluntary, non-profit agencies (such as Blue Cross and Blue Shield) or commercial underwriters of federal programs (such as Medicare and Medicaid) - diffuse the educational costs throughout the population through their premium charges or taxation. These insurers have a social obligation to support graduate medical education, for the education and training of future practitioners is an essential investment by the public provided through private health insurance and government programs. This investment ensures that medical care needs of future generations will be met."

The SNMA strongly feels that other areas to reduce the federal deficit and enhance the stability of the Hospital Insurance Trust Fund have not been fully explored. There are other ways to decrease total Medicare costs than those already stated. The SNMA suggests the following:

1)streamlining of administrative costs of the program to create a more efficient operation of the poogram.

2)policies to allow and encourage individuals 65 years of age and older to continue working as long as they desire and as long as they are physically and mentally fit, thereby delaying the use of the Medicare Program for several years.

3)a more extensive effort to promote preventive health care habits extending beyond media advertisements to lead to a healthier population in the long-run, decreasing the necessity for hospitalization, and, finally

4) 4)Provide tax reforms to create incentives for families to take care of the elderly at home and to enable families and individuals to afford and desire home health care particularly for chronic illnesses that can be cared for at home.

Conclusion

The SNMA firmly believes a stable source of financing graduate medical education must be maintained. Currently, more than 80 percent of these costs are paid for by means of reimbursement from cost-based payers and charges to others. Teaching hospitals are reimbursed for their direct costs on a pass-through basis at 100 percent of "reasonable costs". According to Mr. Dole our Nation's teaching hospitals are in large part the guardians of the high standards we demand from our health care system. Teaching hospitals and residents are currently lodged in an economic environment which stresses competition, cost consciousness and cost control, the latter defined by Kohler's Dictionary for Accountants as the employment of management devices in the performance of any necessary operation so that preestablished objectives of quality, quantity, and time may be attained at the lowest possible outlay for goods and services (emphasis added).

Given the complexity and interdependent nature of graduate medical education, undergraduate education, and patient care; the disadvantaged competitive position of teaching hospitals due to their special missions; and the continued shortage of physicians in certain areas of the country any attempt to reform the direct financing of graduate medical education must be undertaken with special care and with the strong knowledge of possible outcomes. Until well studied and appropriate stable alternatives of financing can be found the SNMA must support the current policies of funding and opposes the proposed reforms for the reasons elaborated in the above discussion.

University of North Dakota
School of Medicine
Grand Forks, North Dakota
58202

April 2, 1985

Senator Quentin N. Burdick
511 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Burdick:

As you are aware, the University of North Dakota School of Medicine has developed a quality medical education program designed to meet the needs of North Dakota and the surrounding states. The program entails both undergraduate and graduate educational components on the continuum from medical school to the completion of residency. My purpose in writing is to obtain your assistance on an issue which may adversely impact on the graduate education portion of our program.

Our specific problem relates to the support of graduate education (i.e. residency training) provided by the Medicare program through stipend support. Under the new Prospective Payment System, support of graduate education is facilitated by two methods: 1) the educational pass-through provided as an offset to hospitals; and, 2) direct support through the provision of stipend funds. Several concerns have been expressed concerning both methods of graduate medical education support. Although changes in the system may be required, recent proposals on the latter issue have caused some concern to the University of North Dakota School of Medicine.

Across the board decreases in the allocation provided for resident stipend support has recently been proposed. However, such a uniform policy neglects the direct support provided by some states for the resident stipend. As an example, at some medical schools the full cost of the resident stipend support is passed on to the Medicare program. Alternatively, some states currently pay a portion of the stipend. In our case, the State of North Dakota pays 50% of the cost resulting in only a 50% pass through to the Medicare program.

We recognize the dilemma in attempting to reduce the costs of the Medicare program and fully support the efforts to contain the costs of the program. States which are already defraying the cost of graduate medical education, however, should not be penalized for their progressive efforts through a uniform cost reduction of Medicare resident stipend support. As an alternative, we would make the following suggestions:

1) Reductions in stipend support should be made according to a regional average. The regional average approach would allow for consideration of the cost-of-living disparities between such residency training sites as New York City and Grand Forks.

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Grand Forks 58202
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2) The percentage of reduction (e.g. 10%) should be applied against the regional average of stipend support provided by the Medicare program. If a program falls below that level of support it would continue to receive the same allocation since the intent of the reductions is to encourage the states to pick up larger portions of the stipend support. In this manner, states like North Dakota that already contribute substantial support to residency stipends would not be penalized.

3) Reductions in future years would continue along the same principle. Once a program fell above the level of support provided by Medicare, the percentage of reduction would apply.

For your perusal and information, I am enclosing a brief hypothetical example of the potential impact of our suggestions. If I can be of assistance, please feel free to contact me at the University of North Dakota School of Medicine. With kindest regards, I am...

Sincerely,

Tom M. Johnson, M.D.
Dean
UND School of Medicine

Kevin M. Fickenscher, M.D.
Director
Office of Rural Health

HYPOTHETICAL EXAMPLE

	Other States		**North Dakota**	
Resident Stipend	= $15,000		= $15,000	
	Medicare	State	Medicare	State
1985	$15,000 (100%)	-0-	$7,500 (50%)	$7,500 (50%)
Average Stipend	$15,000		$15,000	
10% Reduction	$1,500		$1,500	EXCEEDS
1986 Stipend (50%)	$13,500 (90%)	$1,500 (10%)	$7,500 (50%)	$7,500
Result:	State picks up 10% of cost		No change since state already picks up 50%	

STATEMENT OF

J. TED HARTMAN, M.D.

DEAN
SCHOOL OF MEDICINE
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

to the

HEALTH SUBCOMMITTEE
COMMITTEE ON FINANCE
UNITED STATES SENATE

Re: Funding of Graduate Medical Education

June 3, 1985

Mr. Chairman and Members of the Committee:

My name is J. Ted Hartman, M.D., and I am Dean of the School of Medicine at Texas Tech University. I am pleased to have the opportunity to provide testimony to this Committee on the financing of graduate medical education, an issue of great concern to me.

Texas Tech University School of Medicine has as its primary mission the delivery of quality undergraduate, graduate and continuing medical education with a balanced emphasis on primary care and specialized care to west Texas. Our school was established in 1969 and opened in 1972. We conduct a decentralized education, patient care and research program at four regional campuses which are located in Lubbock, Amarillo, El Paso and Odessa/Midland.

We have responded to the mandate to provide primary care physicians for the people of west Texas. 70% of our medical students enter residencies in the primary care specialties at the conclusion of their formal medical school training. 73% of our residency training programs are in the primary care specialties.

The 1982 practicing physician to population ratio for the Texas Tech School of Medicine catchment area was 1:1001, higher than either the state of Texas ratio of 1:719 or the national ratio of 1:609. Our residency programs continue to grow in direct response to the manpower needs of our region.

Mr. Chairman, I am greatly concerned that in an increasingly competitive health care environment it will become more difficult for our teaching hospitals to successfully support themselves while rendering care to those patients who are most critically ill or hopelessly indigent. I concur with Senator Dole's commitment to "impose fiscal restraint without causing undue and potentially harmful disruption in graduate medical education." However, it is my hope that we can work together to develop provisions which will allow the government to continue to increase support to those institutions which are growing in response to the manpower needs of the regions they serve. To simply freeze Medicare payments for graduate medical education without regard to this essential growth would be detrimental to our programs and the patients we serve.

The extent of Medicare support for GME programs has been addressed in your legislation. I wish to recommend that the federal government support the number of positions which is equivalent to the number of graduates of LCME-approved, U. S. medical schools.

Graduates of American schools have consistently chosen residency training programs of high quality. Only those programs of graduate medical education whose residency positions are filled by a majority of graduates of LCME-approved, U.S. medical schools should be eligible to receive federal funds for the support of their programs.

On the issue of the number of years which is appropriate for funding of graduate medical education fellowship positions in the various specialties, I concur with Senator Bentsen that this question has yet to be resolved. While I believe it is appropriate to limit Medicare financing of GME positions at five years, I strongly agree with my internal medicine and pediatric colleagues that the clinical year of fellowship programs in these specialties should receive funding support.

In our area of the country, all specialists provide a significant portion of primary patient care. In health manpower shortage areas, the reality is that all physicians provide primary care. I do not believe that it is appropriate for the level of available funding to determine the viability of subspecialty training programs. I concur with Senator Bentsen's belief that "the residents themselves are perhaps the most competent judges of how best their talent may be applied."

Senator Durenberger has clearly related that "it was not the purpose of Medicare to fund nonservice-related research activities." I concur. Therefore I recommend that consideration be given to funding the one clinical year of training in those subspecialties of internal medicine and pediatrics which are so heavily engaged in the delivery of primary care.

Mr. Chairman, I truly appreciate this opportunity to provide testimony and I look forward to continuing to work with our distinguished senior Senator, Lloyd Bentsen, Senator Dole and yourself on this issue of vital importance. Together, we have the opportunity to assure the continued excellence of this Nation's medical education system. I would be happy to respond to any questions Members of the Committee may have.